

More About Combined Parent-Child Cognitive Behavioral Therapy for Families that Physically Abuse
(CPC-CBT)

The main article contains a general description of CPC-CBT. This information supplements what could be included in the printed issue of Volume 95.

Research Support

Dr. Melissa Runyon and her colleague, Dr. Esther Deblinger, developed CPC-CBT through a series of research studies. An initial pilot study was conducted to address the feasibility of a 16-week CBT group approach that incorporated the child into the parents' therapy (Runyon, Deblinger, & Schroeder, 2009). The group format was chosen because of a belief that guarded populations (such as parents who physically abuse) may benefit more from suggestions and interactions with peers rather than from input from the therapist alone.

In a pilot study with 12 parents and 21 children, both parents and children reported pre to post treatment improvements after their participation in CPC-CBT. Specifically, parents and children reported reductions in the use of physical punishment, and improvements in parental anger towards their children, more consistent parenting, as well as improvement in children's PTSD symptoms and behavioral problems (Runyon et al., 2009). Dr. Runyon notes that in the first controlled trial, the attrition rate was only 12% if families attended the first three sessions with the primary focus of these sessions being engagement. While pilot data indicated positive changes, there was no follow-up, so it is unclear if the positive changes at the end of the 16-week treatment were maintained over time. These pilot data suggested the potential value and feasibility of having the child and the parent who engages in abusive or punitive behavior participate in sessions together and directly discuss the abusive experiences while learning effective communication and coping skills individually and together.

In a 2010 study, Runyon, Deblinger, and Steer compared the relative efficacy of CPC-CBT (24 parents, 34 children) to Parent-only CBT (20 parents, 26 children). Children were assessed on emotional

and behavioral functioning prior to treatment, after 15 treatment sessions, and 3 months after completion of the treatment. The children and parents in the CPC-CBT group demonstrated greater improvements in resolving PTSD symptoms and improving parenting skills when compared to the Parent-only CBT group. A three-month follow up demonstrated that the treatment gains after 16 sessions were maintained.

To examine the feasibility of and outcomes associated with individual CPC-CBT, the study examined pre and post pilot data for 24 children and their parents, after completing 16-20 individual sessions of CPC-CBT. Preliminary analyses demonstrated that children reported significant reductions in children's PTSD and depressive symptoms while parents reported improvements in their levels of depression, in parenting skills, and in children's internalizing and externalizing behavior problems (Runyon, Deblinger & Schroeder, 2010).

Researchers in Sweden have replicated the findings of the initial CPC-CBT pilot study (i.e., Runyon et al., 2009) with most participants receiving individual CPC-CBT (Kjellgren, Nilsson, & Servin, in press). In their pilot study, they examined pre to post treatment changes for 26 parents and 25 children. After their participation in CPC-CBT, parents reported a significant decrease in parent-reported depression, violent parenting tactics, and inconsistent parenting as well as significant improvements in children's reports of trauma and depressive symptoms. Children also reported significant decreases in violent parenting tactics and improvements in positive parenting.

Treatment Description

A priority of CPC-CBT is to closely monitor the family and continually reassess for recurrence of corporal punishment or physical abuse. In addition to lowering the risk of violence, goals are to help parents' correct unrealistic expectations and misinterpretations of child behavior, to increase positive interactions, and to improve children's overall emotional adjustment. The treatment utilizes modeling, role plays, behavioral rehearsal, praise, corrective feedback, and homework assignments.

CPC-CBT consists of four phases of therapy. The Engagement & Psychoeducation Phase involves the use of engagement strategies, motivational interviewing/consequence review, and individual goal setting to engage, initiate change talk, and to motivate parents who are not contemplating changing their parenting style or interactions with their children.

Early in the treatment, parents are asked to review experienced and potential consequences of physical abuse (short- and long-term behavioral and emotional effects). Parents are also educated about the ineffectiveness of physical abuse in making positive, lasting changes in child behaviors. Violence psychoeducation includes education for both parents and children about different types of violence, the continuum of coercive behavior, and the impact of violent behavior on children, as well as education for parents about child development and realistic expectations for children's behavior. Also, CPC-CBT addresses parental history of trauma exposure and its impact on their relationships with their own parents and their parenting approach with their children. Developmental and normative information is provided. Parents are helped to identify and correct inaccurate thoughts (such as believing that the child is deliberately trying to make a parent angry).

During Phase 2 (Effective Coping Skill Building), CPC-CBT focuses on empowering parents to be effective by working collaboratively with them to develop adaptive coping skills (i.e., cognitive coping; anger management; relaxation; assertiveness; self-care; problem solving) to assist them in remaining calm while interacting with their children, to develop non-violent conflict resolutions skills, to develop a variety of problem-solving skills related to child rearing, and to acquire non-coercive child behavior management skills. Skills also generalize to other areas of the parents' lives. Parents learn the dynamics of their interactions with their children, what escalates anger and violence during these interactions, and how to use skills to diffuse the situation. Parents are taught to identify antecedents, behaviors, and consequences of interactions with children. These skills help parents modulate behaviors and deal more

effectively with child behaviors. Parent sessions also focus on increasing social support, reducing isolation, and allowing parents emotional outlets.

Children are taught effective skills. They are educated about various forms of abuse, taught to identify their feelings, and taught emotional regulation skills, cognitive coping skills, anger management, and social problem-solving. Modeling, rehearsal, praise, and constructive feedback are used to teach skills.

During Phase 3 (Family Safety Planning), family members develop 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. Children also learn about personal safety and practice the safety plan that is developed by the parent. Joint parent-child interaction sessions provide therapist the opportunity to coach and help with the implementation of skills.

The Abuse Clarification process is the final phase of therapy. The creation of the trauma narrative with the child needs to wait until the parent has shown some improvements. Since the child is remaining in the home with the parent who perpetrated the abuse, he or she may be reluctant to relate details about the victimization. The child and the parent may be engaged in a negative cycle of berating and harshness that is damaging, but does not meet legal criteria for abuse. To assess readiness for sharing about the trauma, therapists should watch for the child reporting positive interactions with the parent and check for feelings of safety about being in the home.

Abuse Clarification involves the parent writing an abuse clarification letter and the child developing a trauma narrative about the abuse experienced. Specifically, the clinician encourages the children to write about or share their abusive experiences while focusing on their thoughts and feelings associated with the abuse. While the child is developing this trauma narrative, the clinician also assists parents in processing their own thoughts and feelings while writing and revising the “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, and correct the child's cognitive distortions concerning the abuse. The parents and children share the clarification letter and trauma narrative in joint segments (unless this process is contraindicated). 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. According to Dr. Runyon, CPC-CBT is the only treatment involving at-risk parents that incorporates the trauma narrative into the clarification process.

Parenting skills training is provided across all phases. CPC-CBT helps families develop effective communication skills to increase family members' feeling of validation and cooperation with one another. Over the course of treatment, joint parent-child sessions involve having parents practice implementation of active listening, communication skills, and positive parenting. The parent tests skills first with the therapist. Then the parents utilize the skills with their children while the clinicians coach them by offering positive reinforcement and corrective feedback to enhance the skills.

Dr. Runyon relates that CPC-CBT is being disseminated both nationally and internationally. For example, four agencies in four cities across the southern portion of Sweden have implemented CPC-CBT with positive results (Kjellgren et al., in press) and plan to conduct a large scale clinical trial. Researchers in Sweden have collected pilot data and replicated the findings of the initial CPC-CBT pilot study (Runyon et al., 2009) and they have plans to conduct a large scale dissemination study. Four agencies in Mississippi participated in a CPC-CBT Learning Collaborative in 2010 through 2011 that was supported by funding from Gulf Coast Mental Health Center, a member of the National Child Traumatic Stress Network. Data collected from the clients of participating clinicians demonstrated significant pre to post treatment improvements for both children and parents.

Training programs for clinicians who want to offer CPC-CBT are described in the article on training opportunities, this issue. Their training model includes a motivational enhancement procedure and places emphasis on teaching clinicians how to engage families.