How to Implement Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)

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Please note that this manual follows the outline and structure of the Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Implementation Manual:

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Preface
I. Preface

Violence is an epidemic that negatively impacts children across their lifespan. Reports indicate 2.1 million youth have experienced physical abuse during their lifetimes with toddlers having the greatest risk. Most cases involve parents who are doing the best they can given their circumstances (i.e., own trauma history, parental role models, mental illness) to assist their children in becoming productive citizens. Unfortunately, some parents feel helpless and lack the skills to effectively parent and move their children towards positive goals. Some parents use physical discipline as a strategy to control their children’s problem behaviors and may use increasing force if children continue to be noncompliant. To decrease coercive parenting situations from escalating as well as the negative effects of physical abuse, all families should have access to services to empower parents to effectively parent, strengthen family relationships, enhance the safety of family members, and help children heal from violence.

Few professionals have the expertise or access to specialized training to effectively help children heal from abuse and stop the cycle of violence in families. Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT) is an evidence based model that empowers families and has been shown to reduce parental use of corporal punishment, to enhance positive parenting skills, and to reduce children’s trauma symptoms. This CPC-CBT Implementation Manual is for clinicians, clinical supervisors, administrators, and other consumers who are considering the implementation of CPC-CBT in their agencies with families at-risk for child physical abuse (CPA). The goal is for this manual to assist interested parties in obtaining an understanding of what is necessary to effectively implement CPC-CBT in their organizations and making an informed decision about choosing to implement CPC-CBT in their agency. CPC-CBT training and consultation is offered with the goal to increase access to quality services to underserved communities across the United States thereby reducing violence in families.

Throughout the CPC-CBT Implementation Manual, the term “parent” is utilized. Parent is defined as any adult caregiver who is in a primary caretaking role of the child. This is not to imply that only biological parents can participate in this program. Foster parents, grandparents, biological parents, and other relatives and caregivers have been successfully involved in the CPC-CBT program.
Why Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)?
II. Why Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)?

Why Should Agencies and Clinicians Consider Implementing CPC-CBT?

Agencies and clinicians are generally interested in implementing a new treatment model because they have a desire to deliver services that have been proven to be effective. CPC-CBT is one of the few evidence based treatment models designed specifically for families at-risk for CPA that addresses the emotional distress of the child in conjunction with the psychosocial difficulties experienced by the parent who engages in excessive physical discipline. To date, two studies have demonstrated that CPC-CBT helps children and families recover from the negative effects of excessive physical discipline/CPA. This supports the promise of CPC-CBT to reduce parental use of corporal punishment, improve positive parenting skills, reduce children’s PTSD symptoms, and strengthen parent-child relationships.

A list of relevant studies can be found in Appendix A.

Here are some important facts.

CPC-CBT:

- is a prevention and intervention model that can be used with a continuum of parents, ranging from those parents who fear they will lose control with their children, to those who engage in coercive parenting strategies, including the use of physical discipline, and those who have been substantiated for physical abuse.
- enhances positive parenting skills.
- reduces parental use of corporal punishment.
- reduces children’s trauma symptoms.
- is effective with children and parents from diverse backgrounds.
- can work in as little as 16 treatment sessions.
- has been delivered effectively in individual and group therapy formats.
- safely incorporates the child into “offending” or at-risk parent’s treatment to strengthen parent-child relationships and to promote optimal outcomes.
• works with a variety of caregivers (i.e., foster parents, grandparents, step-parents, biological parents).

In cases of CPA, it is often in only the most severe cases of abuse (i.e., broken bones, head injury) that a child is removed from his/her home and the parent is restricted from having contact with the child. A majority of children remain in the home with the parent who abused them and treatment is recommended as part of the child protection case plan. Historically, the standard of care in community settings across the United States for this population has been to refer parents to parenting classes, which inadvertently neglects the needs of the traumatized child as well as the parent-child relationship. It is not surprising that after parents participate in large group parenting classes, a large number of these families relapse with additional abuse allegations being reported within three to six months after treatment has ended.

Given the multifaceted needs of these families, a comprehensive approach that meets both the needs of the parent and the child is warranted. CPC-CBT can be utilized as a prevention and intervention model to address the needs of families on a continuum of coercive parenting, ranging from those parents who fear they will lose control with their children to those who engage in coercive parenting strategies and those who have been substantiated for physical abuse. Indeed, it is critical to stop the coercive behavior or ongoing physical abuse to enhance the child’s safety and to teach parents effective, non-violent disciplining strategies. It is equally important to help the child heal from the emotional trauma experienced that is related to the physical abuse he/she has endured and to enhance the parent-child relationship. CPC-CBT was developed to address these complex needs.
An Overview of CPC-CBT
III. An Overview of CPC-CBT

What Is Combined Parent Child Cognitive Behavioral Therapy (CPC-CBT)?

Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT) is a model designed to address the needs of children and families at-risk for CPA developed by Melissa K. Runyon, PhD in collaboration with Esther Deblinger, PhD. CPC-CBT has been identified by the National Child Traumatic Stress Network (NCTSN) as a promising practice and is currently being reviewed for inclusion in the National Registry of Evidence based Practices and Programs (NREPP).

Goals of CPC-CBT include helping children heal from their abusive experiences, empowering parents to effectively parent their children in a non-coercive manner, strengthening parent-child relationships, and enhancing the safety of all family members.

What Are the Skills of CPC-CBT?

CPC-CBT is a manualized treatment consisting of 16 sessions offered over the course of 16-20 weeks in either individual (90-minute sessions) or group (2-hour sessions) format. Every session begins with the parent and child meeting individually with the clinician and concludes with the parent, child and clinician together. The amount of time spent jointly with the parent, child and clinician increases as therapy progresses. By the end of the course of treatment, the majority of the session is spent jointly with parent, child and clinician.

The treatment consists of:

1. Parent Interventions,
2. Child Interventions, and

Some of the skills emphasized in the structured therapy sessions include:

Engagement Strategies/Motivational Interviewing

- The use of engagement strategies, motivational interviewing/consequence review, and individualized goal setting to engage and to motivate parents

CPC-CBT empowers parents to use effective, positive parenting skills, assists children in overcoming the trauma of physical abuse, and strengthens parent-child relationships.
who are often not contemplating changing their parenting style or interactions with their children.

**Psychoeducation: Violence, Child Development, Processing Parent’s Relationship with Own Parents**

- Providing parents with information concerning emotional and behavioral effects on children of severe corporal punishment and CPA as well as processing the impact on their childhood experiences particularly if they experienced abuse themselves.
- Providing education about child development and age appropriate expectations for children’s behavior

**Enhancing Positive Coping Skills in Parents**

- Empowering parents to be effective by working collaboratively with them to develop adaptive coping skills (i.e., anger management, relaxation, assertiveness, etc.) to assist them in remaining calm while interacting with their children, to develop non-violent conflict resolution skills, to develop a variety of problem-solving skills related to child rearing, and non-coercive child behavior management skills.

**Enhancing Family Communication Skills and Positive Parenting Skills**

- Helping families develop effective communication skills to increase family members’ feelings 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 with children while the clinicians coach them by offering positive reinforcement and corrective feedback to enhance the skills.

**Enhancing Positive Coping Skills in Children**

- Teaching children a variety of positive coping skills, particularly assertiveness and anger management skills training, given that children who are exposed to physical violence are much more likely than other trauma populations to present with aggression.
**Family Safety Planning**

- Developing 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. Joint parent-child sessions involve having parents and children rehearse the implementation of the family safety plan.

**Abuse Clarification Process**

- During the last phase of treatment when improvements have been reported in parent-child interactions, positive parenting, and children’s fear, the child begins to develop a trauma narrative and the parent writes a letter in which he/she takes full responsibility for his/her abusive behavior and relieves the child of fear and self-blame for the abuse. The trauma narrative and abuse clarification process have been integrated so the parent can directly address some of the child’s fears and feelings of self-blame as stated in the trauma narrative in the abuse clarification process. Joint parent-child sessions involve having parents and children communicate openly about the violent experiences between them.

**What Population Does CPC-CBT Effectively Serve?**

Children (ages 3-17) and their parents who are at-risk for or who have already engaged in physically abusive behavior towards their children are appropriate referrals. At-risk may be defined as those families who have had multiple referrals to Child Protective Services (CPS) with no substantiation, as well as those families who report using excessive physical punishment with their children. It may also include parents who experience high levels of stress, perceive their children’s behavior as extremely challenging, and fear they are going to lose their temper with their children.

- Contact between the child and the parent must be permitted
  - Either the child remains in the home with the parent who engaged in the excessive physical discipline; or
  - the child has been removed from the home but there is a clear plan for reunification and frequent contact between the parent and child is permitted.

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Families who have not been substantiated for child physical abuse can benefit from CPC-CBT as it may be used as a preventive measure so that coercive interactions in the family do not escalate to a level that meets state statute definitions for substantiated CPA.
• Supervised contact is acceptable but it must be in addition to the contact the family has during the CPC-CBT sessions. The family should have contact at least once per week (outside of session) to practice the skills learned in session with increasing contact as therapy progresses.

• The identified parent must be willing to participate and other caregivers in the home are strongly encouraged to participate.

• Children must be verbal.

It is helpful if an agency has an existing referral base for the population described above or the ability to partner with a referral source that does. In many instances, agencies already serve the population described above but are not screening for child trauma and coercive or abusive parenting behaviors. The use of an intake screening and assessment protocol can help identify appropriate CPC-CBT clients amongst an existing client base. A suggested screening process is outlined on page 30.

When Is CPC-CBT Not the First-Line Treatment of Choice?

CPC-CBT is not an appropriate intervention for families where the child has been removed due to CPA and there is no plan for reunification. It is contraindicated to have joint therapeutic sessions with a parent and child when the plan is to terminate parental rights.

In situations where there is a no-contact order due to safety concerns, but there are no plans to terminate parental rights, CPC-CBT may be appropriate. The court may decide to lift the no-contact order to allow the family to receive services, such as CPC-CBT. However, CPC-CBT services can not be initiated unless the court permits some contact between the parent and child.

CPC-CBT may not be appropriate in cases where adolescents are engaging in dangerously assaultive behavior toward their caregiver and others. These behaviors are exclusionary when they represent an ongoing pattern of coping behavior both in and outside of the home and are not in an effort to protect themselves from the parent.

CPC-CBT may also not be appropriate in cases where the child(ren) has no capacity for language either because he/she is too young or due to severe Mental Retardation or a Pervasive Developmental Disorder. The term severe would be defined as those children who function below the developmental age of 3-years-old or those who have no capacity for language.
CPC-CBT is not appropriate in cases where the parent is the perpetrator of both sexual abuse and physical abuse.

There are a number of other clinical issues that may delay the initiation of CPC-CBT:

- Child/Parent is imminently suicidal or homicidal and needs crisis intervention (may be appropriate after stabilized).

- Parent has a significant drug/alcohol problem associated with a level of impairment that interferes with his/her ability to participate in treatment (may be appropriate after stabilized). With regard to parental substance abuse, a parent may be required to complete substance abuse counseling prior to initiating CPC-CBT. In other cases, parents may complete substance abuse counseling concurrently with CPC-CBT.

- Parent or child has significant mental illness associated with a level of impairment that interferes with his/her ability to participate in treatment (may be appropriate after stabilized). Parents and/or children with significant mental health issues should be referred for a psychiatric evaluation and be monitored for ongoing medication use in conjunction with CPC-CBT.

What Symptoms Does CPC-CBT Effectively Address?

CPC-CBT has been associated with emotional and behavioral changes for both parents and children in a number of important areas:

- Improvements in positive parenting skills;

- Improvements in behavioral problems such as aggressive behavior, oppositional behavior, and refusal to do what the parent asks;

- Improvements in children’s PTSD symptoms;

- Reductions in parental use of physical punishment reported by both parents and children;

- Reductions in inconsistent parenting; and

- Reductions in parental anger toward their children
Implementing CPC-CBT
IV. Implementing CPC-CBT

Agency Stakeholders: Commitment Within and Outside Agencies

Successful implementation of CPC-CBT, or any evidence-based treatment model, in an agency requires the support of a variety of individuals and groups. Engaging and obtaining a commitment from all these critical stakeholders makes implementation easier and more effective.

Steps in Implementing CPC-CBT: What does it take?

The NCTSN (Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network, 2004) has identified the following four steps as important in implementing an evidence-based practice such as CPC-CBT: 1) organizational readiness, 2) pre-implementation training, 3) implementation, and 4) sustaining the practice.

NCTSN (2004) defines these concepts as noted in quotation marks below.

- **Organizational readiness** is defined as “how ready an organization is to make the changes required at various organizational levels to successfully implement and sustain a new practice (p.15).” Adopting and sustaining a new practice is challenging and will likely require support by and change at all levels of the organization. The information in this manual will assist agencies in determining their readiness to implement CPC-CBT.

- **Pre-implementation training** is defined as “the multi-step process required to prepare agencies for implementing a new practice (p.15).” Staff at all levels of the organization (clinicians, administrators, clinical supervisors, and support staff) should be informed of the new practice and commitment should be obtained from the beginning of the process. It is necessary for change to occur at all levels for successful implementation. As such, the NCTSN Learning Collaborative (LC) training methodology (refer to page 42 for more information) is incorporated into CPC-CBT training and requires that the agency’s implementation team include an administrator, clinical supervisor (who will be asked to implement CPC-CBT with two cases during the learning process), and at least 2 clinicians. The training consists of in-person training and ongoing telephone consultation in the implementation of CPC-CBT.

- **Implementation** is defined as “actually putting into play the coordinated efforts of staff, clinicians, supervisors, and administrators so that [CPC-CBT] is provided effectively in an organization (p. 15)”.

How to Implement Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)
• **Sustaining the practice** is defined as “having a plan in place to ensure that the agency will continue using [the evidence-based practice] in a self-sustainable way after the training and consultation calls have ended without the support of expert consultants, ongoing training, or even supervisors who may leave to take other jobs (p.16)”.

Our developers and trainers would like for your agency to be successful in your implementation of CPC-CBT. Successful implementation of CPC-CBT (or any program) can be affected by how well prepared a staff and organization is to use the model. Some guidance and considerations to help optimize your use of CPC-CBT are outlined below.

**Information for Program Administrators**

There are several important points that program administrators should take into account when considering adopting CPC-CBT.

Support by leadership in an agency is critical for learning and adopting a new therapy model such as CPC-CBT. Leadership must be committed to supporting their staff in learning and using the new model. The following steps are recommended for successful learning and use:

- Become familiar with our implementation and training programs to ensure that the agency and staff can meet the training requirements.

- Obtain a commitment from staff in advance and educate them about what CPC-CBT is and why it is being adopted.

- Offer an orientation meeting to educate staff about CPC-CBT. CPC-CBT trainers can be available to participate in a staff orientation meeting for those agencies who are considering learning and using the model. During the meeting with leadership and/or CPC-CBT trainers, staff will be assisted in expressing barriers or concerns about learning and using CPC-CBT and identifying strengths to overcome them.

- Ensure that staff at all levels including supervisors, direct service providers, and administrators (Senior Leaders) are committed to both in-person training and ongoing consultation. The recommended training program consists of a pre-work phase, three 2-day learning sessions (spaced over the course of 8-12 months), and consultation calls that occur twice per month between the learning sessions. Trainers may review randomly chosen audio recordings of role plays and client sessions for at least one cycle of CPC-CBT treatment and offer feedback on consultation calls. Less intensive CPC-CBT training programs are available (refer to page 42).
• Emphasize the importance of delivering CPC-CBT or any other new model to families in the way it was designed. If it is offered in a different way, it may not be as effective. There is flexibility in CPC-CBT and it may be tailored to the agency’s or client’s needs. However, changes should be discussed with CPC-CBT trainers to ensure that there is a balance between tailoring and fidelity to the model (providing therapy within the framework of the model). Refer to page 44 of this manual for additional information on the topic of fidelity and adherence.

• Ensure that CPC-CBT caseloads for staff learning a new model are appropriate (2-4 families while learning, 4-6 after proficient in the model), and that staff members have time to participate in training and complete all other work assignments.

Depending on how extensively an agency expects its clinicians to change their current practices, agency-level adjustments may be required to implement CPC-CBT. As with learning any other new skill, adopting and adapting a new model of psychotherapy will take time and energy. Program administrators should expect that clinicians will need some time to gain these new skills. They may need extra supervision time and expert consultation time, and it may take more than 16 sessions to implement the CPC-CBT model in the beginning. Administrative support in the early stages of this process often results in more efficient use of clinician time and greater clinician competence in using CPC-CBT later on.

For the optimal implementation and sustainability of CPC-CBT in your agency, live training that incorporates NCTSN’s LC methodology is recommended. There are three CPC-CBT training options available to organizations. These options are described on page 42 of this manual.

Training in an evidence based model, such as CPC-CBT, maximizes client benefits. It is also a major commitment, therefore staff should be aware of what training in CPC-CBT that incorporates the LC methodology consists of and what is expected of them:

Clinician responsibilities include:

• Completing pre-work which includes CPC-CBT training application, reading materials, screening/assessment training through webinar or videoconferencing, and identifying 2 clients who are appropriate for CPC-CBT prior to the first learning session;

• Attending two or three 2-day learning sessions in CPC-CBT depending on the training program selected;

• Participating in at least 80% of scheduled case consultation calls and completing monthly metrics in regards to the use of CPC-CBT between learning sessions; and
• Demonstrating skills and adherence to the CPC-CBT protocol through randomly selected audio recordings of role plays/client sessions reflecting one course of CPC-CBT or review of client sessions/role-plays on consultation calls.

CPC-CBT is very structured and there are specific protocols to follow that include observational assessment, modeling, role plays, and providing feedback to parents. Agency leadership should give careful consideration when identifying which clinicians will learn and use CPC-CBT with families.

• Good candidates to become CPC-CBT clinicians are individuals who are:
  o Comfortable and open to using structured interventions with parents and children.
  o Comfortable working (in a supportive and non-judgmental manner) with parents who may have physically harmed their children.
  o Open to learning and using a new and effective therapy model.
  o Creative and flexible in delivering services to families.
  o Open and responsive to supervision and feedback.

• Clinicians who implement CPC-CBT should have a Master’s degree or higher in one of the mental health professions or be working towards one of these degrees under the supervision of a licensed mental health professional.

• Given that CPC-CBT is based on cognitive-behavioral principles, it is helpful but not necessary for clinicians to be well-grounded in CBT.

Information for Clinical Supervisors

Clinical supervisors are critical to the successful implementation of CPC-CBT or any evidence based intervention. Clinical supervisors who are trained in CPC-CBT will be responsible for providing training and ongoing, on-site supervision in CPC-CBT to supervisees in their agencies after the training and consultation with the trainers has ended. They will oversee the implementation of CPC-CBT thus, it is imperative for them to perceive CPC-CBT as valuable for families.

Here are some key reasons why clinical supervisors are interested in supporting the implementation of CPC-CBT:

• Clinical supervisors are committed to providing the best services to clients.
Many parents being served in community mental health centers are at-risk for CPA or have significant stressors associated with parenting but these risk factors have not been identified upon initiation of treatment. CPC-CBT offers an effective strategy to address the needs of families already being served in the center.

CPC-CBT uses common sense strategies that are consistent with and/or similar to strategies already being utilized by clinicians.

CPC-CBT has a step-by-step treatment manual that is easy to follow by those clinicians who are learning the model.

For CPC-CBT to be implemented effectively, it is imperative for clinical supervisors to:

- be involved in the training and consultation calls,
- implement CPC-CBT with families themselves, and
- monitor staff’s cases, provide ongoing, on-site clinical supervision, and to assist staff in adhering to the CPC-CBT model.

Information for Clinicians

Here are some key factors for clinicians to keep in mind when considering the utilization of CPC-CBT in their clinical practice:

- CPC-CBT involves effective strategies for engaging resistant families and motivating them to change behavior.
- CPC-CBT helps reduce parental use of corporal punishment, enhance positive parenting skills, and reduce children’s trauma symptoms.
- CPC-CBT helps parents accept their children as they are while building on their natural strengths.
- CPC-CBT is a common sense approach that is consistent with the therapeutic techniques that many clinicians are already using with their clients.
- CPC-CBT takes a non-judgmental approach to empowering parents to change behavior and focuses on building family strengths.
- CPC-CBT empowers clinicians by producing significant clinical changes in clients in a short period of time.
- CPC-CBT is one of the few evidence based therapies available to assist families at-risk for physical abuse in meeting their treatment goals.

### Information for Families and Children

It is important to communicate these key points about CPC-CBT to families and children:

- Raising kids is not an easy job. We know that parenting can be stressful. We also know that some children are more difficult to parent than others. CPC-CBT was developed with this in mind. This program can help make your job as a parent easier and more enjoyable.

- The goals are to reduce children’s problem behaviors, reduce the stress you feel as a parent, and help you and your child get along better.

- The program can also help families cope with tough situations, reduce stress, manage anger, and improve your relationship with your child.

- Common goals parents have when they participate in this program include getting their children to: cooperate more, take “no” for an answer, act out less, and do better in school.

- CPC-CBT has been proven to work in as little as 16-20 sessions.

- CPC-CBT works with parents collaboratively—you are expert on your child and in this program we will work as a team to discover what works best for you and your child.

### Information for Community Referral Sources and Third Party Payers

It is important to communicate these key points about CPC-CBT to community referral sources and third party payors:

- CPC-CBT is not only an intervention model but also a prevention model. It is effective in working with families who have already experienced an abusive situation to decrease the possibility of the reoccurrence of violence. It is also effective in working with parents who are concerned they might lose control with their children and who are experiencing a lot of stress. These families are offered support to reduce the possibility that they will lose control with their children.
CPC-CBT is a short-term prevention and intervention model that can produce positive and lasting outcomes for parents and children in 16-20 sessions.

CPC-CBT is cost effective given that it works in a brief period of time. In fact, one study indicated that 95.5% had no recurrence with only 4.5% having one new report of physical discipline to CPS after their completion of the program. In addition to reducing the use of current abusive parenting strategies, CPC-CBT can also reduce the likelihood of parent-child conflict escalating to substantiated abuse. It can reduce the future costs of care for families who did not receive such care at an early stage of their parent-child conflict.

CPC-CBT is more comprehensive and interactive than traditional parenting classes and has been associated with more positive outcomes for families. It has also been associated with improving positive parenting and reducing physical discipline.

CPC-CBT incorporates culturally sensitive materials and has been proven to work with parents and children of various ages and ethnic and racial backgrounds.

It can be offered in group or individual format to meet the needs of a particular agency’s referral base (e.g., volume of referrals, families who prefer not to be in group, etc.)

CPC-CBT and Reimbursement

There are many ways to get funding for CPC-CBT. Please confirm that your agency has funding sources that will reimburse for CPC-CBT services. A course of individual CPC-CBT consists of 16-20 weekly 90-minute sessions. A course of group CPC-CBT consists of 16-18 weekly 120-minute sessions. Funding sources should be billed for an initial assessment to identify treatment targets and should allow for billing of separate sessions with both the child(ren) and parent(s) and then a “joint” or family session with both the parent(s) and child(ren).

CPC-CBT assessment and therapeutic services may be billed through:

- Medicaid as separate services including individual for the parent, individual for the child, and family sessions (regulations may vary from state to state).
- A contract with your state CPS agency or other entity to provide evidence-based services for fee for service.
• Many insurance companies.

• Victim of Crime Compensation Agencies (VCCA). Note: VCCA will pay for child and family sessions but not the individual work with the parent.

Managed care exists to improve the quality of services that children and families receive. CPC-CBT is a short-term, evidence based, cost effective model that is associated with positive outcomes for children and parents. Agencies can educate managed care companies about the benefits of CPC-CBT and make application to be a member of their preferred provider network for reimbursement.
Delivering CPC-CBT
V. Delivering CPC-CBT

Clinician Qualifications and Skills

Clinicians who implement CPC-CBT should have a Master’s degree or higher in one of the mental health professions or be working towards one of these degrees under the supervision of a licensed mental health professional. Given that CPC-CBT is based on cognitive-behavioral principles, it is helpful but not necessary for clinicians to be well-grounded in CBT.

It is important for clinicians to prepare themselves to work in a supportive, non-judgmental manner with parents who have harmed their children in some way. Most parents who have physically harmed their children have done so as a result of their inability to effectively gain their children’s cooperation and compliance. Many of these same parents have experienced violence during their own childhoods and have not developed effective outlets for managing their own distressing histories or frustrations. Most children who have been physically abused remain in the home with their parents and the parents are required to complete a case plan that involves therapy. While it may feel counterintuitive for a child clinician to work with a child and the parent who hurt him/her, progress may be limited by working with only one aspect of the system. In fact, working with the child alone may inadvertently increase the child’s risk for harm if the clinician has not obtained the parent’s commitment to treatment and their approval and support of the skills being introduced to the child (i.e., safety skills, assertiveness skills).

How CPC-CBT Fosters Cultural Competence

A few important points regarding beliefs about corporal punishment and parenting in the context of culture should be considered when providing treatment to this population. Corporal punishment is widely accepted across the United States as an acceptable form of discipline despite the fact that 23 nations have deemed corporal punishment of children by their caregiver as illegal. This belief cuts across all ethnic, cultural, and professional groups. Research has identified beliefs in favor of corporal punishment as a risk factor for CPA. Studies examining the use of corporal punishment among specific cultural groups have produced inconsistent results. Given the variability of research in this area and the fact that certain factors regardless of ethnic group are associated with the use of physical punishment and/or CPA, it is important for clinicians to be open and respectful of all families’ cultural beliefs and values and not to assume that any one ethnic or cultural group is more prone to use corporal punishment or to physically abuse their children than another. While corporal punishment is not against the law and it is different from CPA, a majority of families who have been referred for treatment have crossed the line and the use of corporal punishment has escalated to excessive punishment or CPA. Other referred families fear they may cross the line and are proactively seeking
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mplement Combined Parent
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assistance. As such, the continued use of corporal punishment is likely to place families at-risk for the occurrence of CPA.

CPC-CBT fosters cultural competence by encouraging clinicians to identify their personal values and beliefs, to acknowledge personal biases and how they may interplay with clinicians’ perceptions of their clients, and to be open to values and beliefs that differ from their own. An underlying tenet of CPC-CBT is that the families are the experts on their culture and children and it is important for clinicians to invite families to educate them in these areas, so the parents and clinicians can work as a collaborative team. Another underlying tenet is to identify strong values and beliefs in families as strengths and to help families utilize these strengths to feel empowered and to produce change (which is consistent with their values) in their parenting relationship with their children. We help families support the values and beliefs that are important to them with their children.

Many cultural considerations were made during the development of CPC-CBT. It is important to note that in the development study of CPC-CBT, 75% of families receiving CPC-CBT identified themselves as ethnic minorities (18% Caucasians, 42% African-Americans, 15% Hispanics, 18% who described themselves as Biracial, and 7% of other ethnic backgrounds). Consumer satisfaction surveys were administered every four weeks during this three year treatment outcome study to all participants. Because the cultural relevance of the model was important to the developers, the treatment model was refined using participant feedback. Some of the efforts toward enhancing the cultural competence/relevance of the model were based on consumer feedback and are notable. 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 being served. For example, clinicians are encouraged to establish a collaborative working relationship with families, a major tenet of CBT. A primary goal is to empower parents to feel as though they are an effective agent of change in their environments, particularly with regard to their children’s behavior. CPC-CBT clinicians also initiate discussions and demonstrate respect for families’ cultural beliefs and traditions and work with families to determine how some new skills might fit into their pre-existing environment and how others might not work. While it is important to be well versed in literature and research findings, clinicians are encouraged to have the individual clients educate them about his/her cultural beliefs and values as there is often variability within cultural groups with respect to their beliefs, attitudes and practices of individual families.

Based on participant feedback, a number of culturally sensitive materials have been incorporated into CPC-CBT. Boyd-Franklin (1989, 1993) cites literature indicating that African-American children are overrepresented in special education classes. CPC-CBT clinicians 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 during the study, the plan was to extricate the children from the regular school system. After clinician involvement, clinicians 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 certain forms of
spanking may have a place in the overall disciplinary program but an exclusive reliance can be counterproductive. Similarly, our approach has been not to tell parents that they are bad or that spanking is bad, but to emphasize their strengths, look for common goals for children, and identify strategies to help their children achieve these goals, including non-violent alternatives to keep their children safe and to avoid any further negative consequences for themselves or their children. Many of our clients have reported using corporal punishment over the course of treatment. They are clearly educated about the differences between corporal punishment and physical abuse and the clinicians acknowledge that corporal punishment is not against the law. Parents are not berated for this behavior. Rather, clinicians review the antecedents, behaviors, and consequences associated with the parent-child interaction in an effort to identify strategies that could have been effective in stopping the child’s behavior or deescalating the situation before it rose to a level where the parent felt corporal punishment was necessary. For most parents presenting for treatment, there is a certain amount of stress associated with situations resulting in physical punishment whether it rises to the level of physical abuse or not. As such, strategies that reduce stress may stop the incident before it escalates have been reported as less stressful by many of the parents. This then reinforces alternative behavior.

We have also incorporated culturally sensitive parenting materials into the protocol, such as Howard Stevenson’s parenting book (Stevenson, Davis & Abdul-Kabir, 2001), articles about praise from Essence magazine, Spanish-language parenting books (Whitham, 2004), and specific chapters and excerpts from Nancy Boyd-Franklin’s book about raising black men. We have also translated some of the handouts into Spanish language for those families who are bilingual but prefer to read materials in Spanish.

A common theme for many families with strong religious beliefs is to speak of “Spare the rod, spoil the child.” In cases where this topic arises, we have incorporated handouts from the internet that describe this phrase as not being literal, but meaning to discipline and to provide clear guidance to your child. In fact, one African-American client with strong faith conducted her own research on the internet as she stated that her involvement with CPS for abusing her son prompted her to do some “soul searching”. She concluded that while spanking her son was “not the worst thing in the world,” she “went too far this time” and “that spanking her son might not be the best course of action”. This mother’s research on statements in the Bible about disciplining children that she shared with her clinician was incorporated into CPC-CBT sessions. The clinician’s place is not to debate this belief or faith with the client, but to capitalize on his/her spirituality as a strength, to agree that disciplining children is an ideal goal for parents to have as it teaches responsibility and builds character; and to assist the parent in identifying and learning many strategies to discipline his/her child.

Boyd-Franklin (1993) also talks about African-Americans’ desire to raise a strong Black man due to the oppression that Blacks have experienced throughout history. She also talks about parents using physical discipline to protect their children by
keeping them off the streets and out of trouble. Many of the clients have made similar statements and have added that they want their children to: stay in school, do better than their parents, and “be good, productive citizens.” Again, these are all reasonable and valuable goals for any parent to have for his/her children. Working collaboratively through CPC-CBT, the parent and clinician can identify numerous ways that the parent can help his/her child achieve these goals. After reading a chapter on this topic from Boyd-Franklin’s book, one African-American parent referred for substantiated physical abuse said “I felt like the authors understood me. They understood why I used corporal punishment. I’ve made some wrongs, but for the right reasons. I didn’t feel like a piece of crap after reading it, but at the same time, I realize it may not be the best way to approach my child.”

With regard to cultural concerns related to oppression and views that discourage assertive behavior, it is true that many cultures, including Asian, Puerto Rican, other Latino cultures, African-American, Native Americans, and others (Fontes, 1993; Fontes, Cruz, & Tabachnick, 2001; Wood & Mallinckrodt, 1990), may perceive assertive behavior, particularly by women and children, as disrespectful, and may refrain from utilizing assertive behavior for fear of being perceived negatively due to issues of discrimination and oppression. While not directly addressed in the literature on physical abuse education and safety skills, researchers have suggested that the cultural beliefs, issues of oppression, and the context of specific situations be taken into consideration when conducting assertiveness training (Wood & Mallinckrodt, 1990) with minority populations. Given this research and feedback from youth, we were respectful in terms of the environmental context in which the youth resided. For example, many of the participants resided in impoverished, highly conflictual urban environments. As such, when skills such as assertiveness skills and safety skills were presented, youth stated that some of the traditional skills might increase their risk for harm from peers. Youth and clinicians were able to develop strategies to respond in high risk situations that did not increase the youth’s risk for harm from peers, but also did not involve responding in a violent manner. In sum, culture (i.e., race, ethnicity, gender, and religiosity) was considered in the development of CPC-CBT to ensure that we are sensitive to various cultural beliefs.

Therapeutic Materials and Activities

In addition to this manual, a session-by-session treatment manual, as well as client handouts, developed by the authors is available to clinicians who are implementing CPC-CBT. Clinicians are encouraged to use a variety of therapeutic activities, games, and other materials to present and reinforce skills that are being taught to children and parents. A complete listing of recommended materials is in Appendix B.
Resources needed for learning and using CPC-CBT

CPC-CBT requires the following materials:

- digital audio recorder and batteries;
- ability to copy (reproduce) handouts and assignments for parents and children;
- access to computer with high speed internet capabilities is preferred, but not required;
- parenting books for parents (see Appendix B for a list of suggested books.)
- initial screening tools, pre- and post-treatment measures (see Appendix C for a list of suggested measures);
- clipboard, pens, and paper
- a variety of children’s therapeutic supplies, markers, crayons, construction paper, etc. to assist with teaching skills, developing a trauma narrative and other therapeutic work; and
- stickers for reinforcing children’s positive behaviors.

Client Selection Criteria

CPC-CBT can be utilized with parents who are at-risk for CPA and those where CPA has already been substantiated by CPS. “At-risk” may be defined as those families who have had multiple referrals to CPS for suspected CPA with no substantiation, as well as those families who report using excessive physical punishment with their children. It may also include parents who experience high levels of stress, perceive their children’s behavior as extremely challenging, and/or fear they are going to lose their tempers with their children.

Screening and Assessment

It is important for intake procedures in community mental health agencies to include screening of violence and abuse in the home, current parenting practices, and trauma history and symptoms in both children and parents. Screenings may consist of a standardized interview and a few brief standardized measures. Guidelines for screening CPC-CBT clients and some specific screening tools are suggested below.

Screening and Assessment of Families to Determine Appropriateness of CPC-CBT
Screening of Families Referred for CPC-CBT

Whether clients are referred to an agency directly from CPS or another referral source, it is important to conduct an intake screening and assessment with parents and children prior to initiating therapy in order to: 1) identify clients who are appropriate for CPC-CBT, 2) identify feelings and behaviors to address in therapy, and 3) document therapy outcomes by providing a snapshot of the client’s functioning prior to and after the completion of therapy.

Appropriate CPC-CBT clients include those who use a continuum of coercive parenting to discipline their children, including those who have been substantiated for allegations of physical abuse, those who have had multiple unsubstantiated allegations of physical abuse, those who are considered child welfare cases with significant parent-child conflict, and those who report using physical discipline and fear they will lose control with their children, as they are at wits end with their children’s behavior. CPC-CBT is conceptualized as both a prevention and intervention model. CPC-CBT was developed to address the needs of families where CPA has been substantiated if they meet the criteria outlined in Section III–CPC-CBT Overview. However, the ideal referral is of a parent who has not been substantiated for physical abuse with the goal of preventing the occurrence of any physical abuse in the parent-child relationship. Unfortunately, most families are not referred to services until after an incident occurs. The screening and assessment process may look a bit different depending on whether the family is referred from CPS or some other referral source.

Referrals from CPS

If a family is referred directly from CPS, they may have been substantiated for CPA which is the first clue that they may benefit from CPC-CBT. However, please note that substantiation is not required for families to be eligible for CPC-CBT. There are a number of additional questions to ask the CPS worker that may be important in determining if the family who is substantiated is appropriate for CPC-CBT:

If the child was removed and is placed in foster care, it is useful to clarify the circumstances given that CPC-CBT is an appropriate intervention for families where the plan is reunification. Please note that if there is no clear plan for reunification of the family, joint parent-child sessions are not appropriate and the family is therefore not an appropriate referral for CPC-CBT.

Questions you can ask to clarify if CPC-CBT is appropriate:

- Was the child removed due to the current referral incident of physical abuse or inappropriate parenting?
- If the child was removed, is there a clear plan for reunification of the family?
• If the child was removed, is the parent allowed contact with the child? How frequent is the contact? Is it supervised or unsupervised? Will participating in CPC-CBT take the place of the visitation or will it be in addition to the visitation?

If there is a clear plan for reunification, the parent and child are having frequent contact in an effort toward reunification, and the parent who engaged in abusive behavior towards the child is willing to participate, CPC-CBT continues to be an appropriate intervention for the family.

• Is the offending parent willing to seek treatment for the referral incident of physical abuse or inappropriate parenting?

The parent who engaged in abusive behavior towards the child must be willing to participate in the treatment process given that treating a child alone who is still having ongoing contact with the abusive parent may actually increase the child’s risk for harm.

There are additional questions that are posed during the intake process that may be useful in determining appropriateness of families for CPC-CBT and developing a treatment plan for families.

• Was the child physically injured during the referral incident? If yes, what was the nature of the injury?

• Has the parent been previously involved with CPS due to CPA allegations? If yes, explain (provide dates, nature of allegations and status of substantiation).

• Was the child physically injured during past incidents? If yes, explain the frequency and type of injuries sustained:

• How many times has the child been removed from the at-risk parent’s home? Explain reasons for removal.

• Were weapons involved in any of the alleged incidents?

• Is there a history of domestic violence between the adults living in the home?

The occurrence of domestic violence should be assessed very carefully as outlined on page 48 in Section VII–Additional Clinical Considerations.

• Is there a no contact order due to safety concerns given the seriousness of CPA and the child’s injuries?
• Has the offending parent previously received treatment to address abusive behavior/ineffective parenting? Specify dates and type of treatment.

• Is the offending parent currently receiving treatment to address abusive behavior/ineffective parenting? Specify dates and type of treatment.

The American Psychological Association ethical guidelines state that a client should not receive duplicate therapeutic services. As such, if a parent and/or child is receiving therapeutic services the clinician should clarify what type of therapy the family is receiving. If the family is receiving services specifically for the CPA, the family should not receive CPC-CBT at the same time as that would be a duplication of services.

• Has the parent served time in jail due to physical abuse allegations? Specify dates and length of sentence.

• Has offending parent served time in jail due to violent behavior other than PA? Specify dates and length of sentence:

• Does the parent currently use drugs? Specify type of drugs.

• Does offending parent have history of drug use? Specify type of drugs.

• Does offending parent currently use alcohol?

• Does offending parent have history of alcohol use?

If a parent has a significant drug and alcohol history associated with a level of impairment that interferes with his/her ability to attend and participate in CPC-CBT, the parent may be referred for substance abuse counseling prior to initiating CPC-CBT. However, the family may be referred back for CPC-CBT after this counseling is initiated if it is determined that the parent is stable enough to participate in CPC-CBT. Otherwise, it is advisable that CPC-CBT not be initiated until the substance abuse counseling has been successfully completed.

If a parent has a drug and alcohol history and is capable of attending and participating in CPC-CBT, the parent may be referred for substance abuse counseling which he/she may complete concurrently with CPC-CBT.

In both of the scenarios described above, it is recommended that the treating clinician obtain appropriate releases and have ongoing contact with the substance abuse counselor to coordinate the parent’s care and closely monitor substance use.

Identifying Appropriate Families Who Have Not Been Substantiated for CPA or Where There Is No CPS Involvement
If there is no substantiation of physical abuse allegations for families and they are not being referred specifically for a risk of CPA or they do not have CPS involvement, the following screening tools can be incorporated into the agency’s intake process to assist in identifying families that may benefit from CPC-CBT:

To identify parents/caregivers who experience parent-child conflict or challenges with parenting, the following simple questions can be asked:

- Is your child's behavior very difficult to manage?
- Have you felt that you are at wits end with your child's behavior and that you might lose your temper when dealing with your child?
- Do you fear that you may lose control with your child’s behavior?
- Have you lost your temper with your child and regretted it later?
- Has spanking been unsuccessful in controlling or changing your child's behaviors?
- Do you need assistance in gaining your child's cooperation?
- Have you lashed out at your child in anger because you just wanted him/her to stop his/her behavior?

If parents respond yes to any of these questions, the Conflict Tactics Scale-Parent Child (CTS-PC) should be administered to both the parent and child. The CTS-PC (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998) is the revised version of the CTS (Straus, 1979), one of the most widely used measures of violent behavior. It assesses violent disciplining strategies utilized by parents. It was also adapted for use with children. The measure yields six subscales: Non-violent Discipline, Psychological Aggression, Physical Assault-Minor Assault, Severe Assault, and Very Severe Assault.

Parents who acknowledge the use of physical punishment by positively endorsing at least two items on the Minor Assault or one item on either the Severe or Very Severe Assault subscales of the CTS-PC are appropriate for CPC-CBT. A mandated report should be made to CPS if a parent or child endorses an item on the CTS-PC that meets the state statute’s definition for CPA. If an abuse report needs to be made, CPC-CBT may be offered to the family after the abuse report has been made as long as it is still clinically appropriate. Please note that a mandated report is not needed in order to provide CPC-CBT to families. If the parenting tactics do not warrant a mandated report the clinician may offer the parent support and skills to decrease the likelihood that the parent will lose control with the child in the future.
A measure that includes a complete trauma history, such as the The PTSD Reaction Index for DSM IV (PTSD-RI; Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) may also be administered to the child to identify physical abuse and other traumatic events as well as the child’s emotional response to the traumatic experience(s). The PTSD-RI is a brief screening tool that quickly and efficiently assesses for exposure to traumatic events and associated DSM-IV PTSD symptoms in school-age children and adolescents. It provides preliminary PTSD diagnostic information. There are three versions: self-report for children, self-report for adolescents, and parent-report on the child/adolescent.

**Assessments to Monitor Clinical Outcomes**

**Pre and Post-treatment Assessments**

After it has been determined that the family is appropriate for CPC-CBT (regardless of whether a family is referred due to substantiated CPA or parent-child conflict), it is important to conduct an assessment to identify treatment targets. Please note that the CTS-PC and PTSD-RI may have been administered as part of the screening to determine appropriateness and need not be administered again as part of the treatment planning assessment.

There are a number of areas that are important to assess as outcomes for families, such as children’s trauma and depression symptoms, children’s behavioral problems, parental depression and anger, and parenting skills.

Conducting an assessment prior to the initiation of treatment as well as when treatment ends is beneficial for both the client and the treating clinician. For clients, assessment results can validate the need for initial and/or ongoing treatment and assist clients in identifying specific treatment goals that they may not be able to verbally express. For example, a child may say, “I feel scared,” but may not specify that he/she has nightmares, can not concentrate at school, and wakes up throughout the night unless specifically asked about those symptoms. Once an assessment reveals these specific symptoms, the clinician can ask the child if it would be helpful to work towards decreasing these symptoms. The clinician also reviews symptoms with parents and children which provides an opportunity for the clinician to normalize some symptoms and highlight those that are unusual. With this population, the parenting measures are administered to both parents and children to provide information about how the clients perceive themselves compared to how their children perceive their parenting abilities. An assessment at the end of treatment provides objective data demonstrating progress or a need for additional treatment to the parent, child, and treating clinician. Objective data demonstrating therapeutic progress can be very empowering for the clinician and family as it proves that their efforts were productive for reaching their goals. An initial assessment also assists the clinician in identifying high-risk clients and salient symptoms, determining which evidence-based intervention is appropriate, and gathering information not disclosed during an interview.
Please note that if someone other than the treating clinician conducts the assessment, it is useful to have the caregiver provide a statement (almost like a police report) of the events that transpired between the parent and child that resulted in them being involved with CPS, if applicable, and subsequently referred for therapy. Refer to Appendix D for form utilized to obtain statement. If the treating clinician conducts the assessment, this is not necessary as it is redundant with the Disclosure of the Referral Incident conducted by the clinician (refer to Sessions 1 and 2 in the CPC-CBT Parent Treatment Manual).

The following are suggested measures to obtain an assessment in the areas described above for both children and parents. This list is not all inclusive. Rather, it is the recommended minimum.

**Parent-Report Measures**

**Alabama Parenting Questionnaire (APQ) - Parent report form (self-report).** The APQ (Frick, 1991) is a 35-item self-report measure that assesses five parenting constructs: Parental involvement, Positive parenting, Poor monitoring/supervision, Inconsistent discipline, and Corporal punishment. Additional items assess discipline strategies other than corporal punishment. Respondents rate the frequency by which they engage in the parenting practices denoted by each item on a scale of 1 (Never) to 5 (Always).

**CTS-PC (clinician administers).** Please see above for a description of this measure.

These particular measures assess parenting skills, an important treatment target for CPC-CBT. The CTS-PC provides specific details of the type of physical discipline utilized which is helpful for treatment planning. A different approach may be taken with a parent who spanked his/her child with a belt, leaving a bruise, as compared to a parent who choked the child leaving finger marks on the child’s neck. The APQ consists of five subscales, positive parenting, poor supervision, inconsistent discipline and corporal punishment, which allows the clinician to tailor the parenting portion of CPC-CBT to meet the parent’s specific needs. For example, if a parent scores low on positive parenting, the program can emphasize positive parenting skills, such as praise, open communication, phrasing consequences in a positive manner, and so on.

The re-administration of these measures across treatment and at the end of treatment provides objective evidence of therapeutic progress and allows the clinician to further tailor treatment to the client’s needs as treatment progresses.

**Child Behavior Checklist (CBCL; either ages 1 ½ to 5 or 6-18: completed by parent about the child).** The CBCL (Achenbach & Rescorla, 2001) is a parental self-report measure which assesses social competence and behavior in children. The CBCL can also be used to measure change in the child’s behavior over time or following treatment/intervention. Parents are asked to provide a rating on a three point scale indicating how true each item is for their child during the past 4 weeks. A rating of 0
indicates not true (as far as you know), a 1 signifies that the item is somewhat or sometimes true for the child, and a 2 is used to designate a very true or often true response. There are two versions of this instrument based on the age of the child being evaluated: one for children aged 1 ½ - 5 and a second version for ages 6 – 18.

Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997; Goodman, Meltzer, & Bailey, 1998). The SDQ is a 25-item screening questionnaire about 3-16 year olds. It asks about 25 attributes, some positive and others negative. The 25 items are divided between 5 scales: 1) emotional symptoms, 2) conduct problems, 3) hyperactivity/ inattention, 4) peer relationship problems, and 5) prosocial behavior. There are four versions of the measure – parent/teacher report for children ages 3 to 4, parent/teacher report for children ages 4 to 10, parent/teacher report for children ages 11-17, and self-report for children ages 11-17.

Parent-reported behavior problems for children are important to assess for this population. Either the CBCL or SDQ may be used to assess children’s behavior problems. The CBCL is well-validated and one of the most widely used measures of children’s behavior problems available to date, the SDQ is another good choice as it has good psychometric properties, is brief and easy to administer, and is available on-line free of charge. The SDQ also assesses the child’s strengths, while the CBCL does not. The specific behaviors identified on a measure of behavior problems guides treatment by allowing the clinician to present parenting skills in an individualized manner that addresses the specific behaviors identified. As parents change their interactions with their children, there should be objective changes in their children’s behaviors on these measures that demonstrate therapeutic progress.

PTSD-RI (Completed by parent on child’s symptoms). Please see above for a description of this measure.

It is important in this population to obtain a thorough trauma history and to assess trauma-related symptoms. As previously mentioned, a trauma history may reveal whether or not a child has experienced child physical abuse as well as other traumatic events (i.e., domestic violence, sexual abuse) that frequently occur concomitantly with CPA. It is equally important to assess trauma symptoms given that as many as one third of children who have been physically abused develop PTSD (Saunders, Berliner, & Hanson, 2004). In one study, 81% of physically abused children presented partial PTSD symptoms (Runyon, Deblinger, & Schroeder, 2009), while children enrolled in another study reported at least four PTSD symptoms on the Kiddie-Schedule for Affective Disorders and Schizophrenia-PL (KSADS-PL; Kaufman et al., 1997), ranging from 4 to 11 symptoms with a mode of 7 symptoms (Runyon, Deblinger, & Steer, 2010). Thus, an important part of treatment is helping children to overcome the trauma associated with their abusive experiences and to cope with their distress. The assessment results assist clinicians in identifying specific trauma symptoms to target in treatment and also assist in monitoring therapeutic progress.
**APQ- Child report form (self-report).** The APQ-Child report form (Frick, 1991) parallels the parental report measure to make direct comparisons possible. Please see above for a description on the parent report version.

**CTS-PC (clinician administers).** Please see above for a description of this measure.

**PTSD-RI (can be administered in interview format or self-report).** Please see above for a description of this measure.

Additional measures are not required but recommended to assess a number of important areas to target in treatment for this population, including:

- **Optional Parent-Report Measures**

  **Beck Depression Inventory** (BDI-II; Beck, Steer, & Brown, 1996). The BDI is a 21-item version of the most widely used measure of depressive symptomatology in adults. Scores from 0 to 9 reflect normal levels of depression, scores from 10 to 18 represent mild depression, and 19 to 29 indicate moderate depression, scores above 30 suggest severe depression.

  In a study using a nationally representative sample, depression has been identified as one of the strongest risk factors for CPA (Chaffin, Kelleher, & Hollenberg, 1996). Specifically, depressed parents were 3.45 times more likely to engage in CPA when compared to non-depressed parents. CPC-CBT may be tailored based on the parent’s level of depression. For example, a depressed parent is likely self-deprecating and may have difficulty getting needs met. As such, the parent with depression may benefit from interventions to increase assertiveness, build self-esteem and self-confidence, and to empower him/her to feel as though she is an effective parent. The clinician may also want to assess whether the children are adequately supervised in cases where the parent has significant depression that may interfere with his/her ability to adequately care for the child(ren).

  **Parental Anger Inventory** (PAI; self-report). The PAI (MacMillan, Olson, & Hanson, 1988) was developed specifically to assess anger exhibited by punitive/maltreating parents when dealing with children’s behaviors and other child-rearing situations for children ages 2 to 12. Parents are asked to rate whether they perceive 50 child-related situations as problematic or non-problematic and rate the degree of anger (on a 5-point scale) associated with the particular situation (e.g., “Your child demands something immediately;” “Your child makes too much noise while you are working.”). Higher scores reflect higher levels of problematic child behavior and anger intensity. The level of anger that a parent experiences in response to the child’s behavior can also assist in guiding treatment. This measure can assist the parent and clinician in identifying external triggers (e.g., children’s specific behaviors) of anger that is useful when assisting the parent in devising an individualized anger management plan to assist him/her in staying calm during child-rearing situations. In cases where a parent does not exhibit anger related to the child’s behavior, less attention may be devoted to anger management strategies.
Optional Child-Report Measures

**Children’s Depression Inventory (CDI)/BDI-II (depending on age of the child; self-report).** The CDI (Kovacs & Beck, 1983) consists of 27 items which assess depressive symptoms in youth ages 8 to 17. The higher the total score, the more depressive symptomatology is present. OR*

* The child will either complete the CDI or the BDI depending on his/her age. For children ages 7-12, a CDI will be completed. For children 13-17, a BDI will be completed. Children ages 3-6, do not complete self-report measures.

**The BDI-II.** Please see above for a description of this measure.

**Ongoing Assessment over the Course of Therapy**

Given the risk associated with working with this population, the Discipline Monitoring Form (Refer to Client Handouts) should be administered weekly to parent(s) and child(ren) separately to monitor positive, negative, and coercive parenting strategies over the course of therapy.

For any client who endorses moderate to severe levels of depression and/or suicidal ideation during the assessment or screening process, clinicians should reassess and monitor the client’s mood and suicidal thoughts closely over the course of treatment.

**Time Requirements and Adjusting the Length of CPC-CBT Treatment**

CPC-CBT is a short-term model that has been associated with positive emotional and behavioral outcomes for children and parents after participation in 16 sessions.

Clinicians may elect to provide additional CPC-CBT sessions in the following situations:

- The parent is particularly distrustful and engagement occurs over the course of multiple sessions prior to the initiation of treatment.

- There are additional incidents of CPA over the course of treatment.

- The family is not progressing to a point where the child feels comfortable and safe enough to begin to process the details of his/her abusive experiences.
• The parent and/or child experiences repeated crisis situations during therapy that prolong the course of treatment.

• Spending more time on each of the CPC-CBT skills, particularly parenting skills for parents who need more concrete, step-by-step instruction or in cases where the child has extremely challenging behavioral disorders that may make behavioral change slower.

• The child has ongoing symptoms of PTSD (e.g., related to multiple traumas), depression or anxiety that have not responded to treatment in 16 sessions.

It is useful to re-administer the assessment measures after 16-20 sessions to identify the need for ongoing treatment as well as specific symptoms to target during the additional sessions being provided.

Advantages to implementing CPC-CBT in the suggested timeframe (i.e., 16 sessions) are:

• Establishing the expectation that treatment will be completed over the course of a specified number of sessions inspires client optimism and may enhance client motivation to attend treatment regularly to complete the program as quickly as possible.

• The expectation that CPC-CBT can and should be completed in 16 sessions may also enhance clinicians’ ability to remain structured and focused in their session planning and implementation.

• The short term nature of the model decreases the tendency for premature treatment drop-out, while increasing the chances of successful treatment graduation.

• The time limited nature of the model increases cost-effectiveness while also allowing more children and families to be seen in a timely manner.
Maintaining CPC-CBT
VI. Maintaining CPC-CBT

Training for the Implementation of CPC-CBT

CPC-CBT’s developers are utilizing National Center for Child Traumatic Stress (NCCTS) Learning Collaborative (LC) methodology to enhance the adoption and implementation of CPC-CBT. These are intended to help agencies gain the necessary clinical and implementation competence to incorporate and sustain CPC-CBT as a part of their current practices.

There are three CPC-CBT training options available to organizations. The first two training options listed incorporate LC methodology. The first is more intensive than the second. Regardless of which of these two training options you choose, it’s important to note the following:

- Trainings that incorporate the LC methodology are not a typical one-time training event. Rather, it is a process of learning, practice, and networking activities designed to enable clinicians to:
  - build evidence-based knowledge and practice skills concerning CPC-CBT,
  - implement, use, and practice those skills on a daily basis with clients,
  - receive expert consultation concerning the cases the clinicians are seeing,
  - measure their progress over time,
  - sustain the use of CPC-CBT in their organization and community long after the training and consultation services have been completed, and
  - provide clinicians with an opportunity to work with LC members to identify and overcome barriers to families receiving CPC-CBT in their community.

- It will also enable brokers to know about CPC-CBT.

- The cost of initial training depends on the type of training preferred and the number of staff to be trained. Three CPC-CBT training options are described below and are available at a range of prices.

The first training option involves a formal Learning Collaborative (LC). A LC consists of pre-work, three 2-day learning sessions spaced over the course of 8 to 12 months.
How to Implement Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)

with consultation calls in the implementation of CPC-CBT occurring twice per month between the learning sessions. To learn more about the LC training methodology and requirements, please refer to LC forms in Appendix E and the LC Implementation Manual (Markiewicz, Ebert, Ling, Amaya-Jackson, & Kisel, 2006).

Agencies may opt for a second training option that incorporates some of the LC methodology, but is relatively less intensive. This involves two full days of in-person training on the model which includes role-plays and performance feedback for approximately $2,000 - $3,000 per day per trainer. Because the program is highly structured, ongoing consultation that occurs twice per month for at least one full cycle of therapy is recommended for clinicians as well. Consultation fees are approximately $260 per hour. Feedback on audio taped client sessions is highly recommended. Two days of advanced training, for the same cost as the initial training, is also available after the initial training sessions to address advanced concepts and questions that arise after clinicians have implemented the model with multiple clients.

For agencies that are unsure if they are able to commit to the above requirements or who need additional information about CPC-CBT to determine if it is feasible to implement the model, a third CPC-CBT training option is available. This option involves two days of introductory training in the model which includes role-plays and performance feedback for approximately $2,000 - $3,000 per day per trainer. However, agencies should not expect staff to be able to fully implement CPC-CBT after a single training event. If after participating in the introductory training, agencies feel as though they are interested in implementing the model, they are eligible to participate in one of the other two training options listed above.

For those that have had training or experience implementing Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), it is worth noting that you will be well prepared for training in CPC-CBT in that there is much overlap in the therapy skills critical to both these approaches. Prior experience in providing trauma education, coping skill building, exposure and processing as well as behavior management as a result of your TF-CBT training will give you that much more confidence in applying these aspects of treatment to families at high risk for child physical abuse. The application of CPC-CBT may, in fact, come more naturally to therapists who have general CBT training. Moreover, the cognitive behavioral principles and philosophies that underlie the design and development of both TF-CBT and CPC-CBT are essentially the same. The differences lie in the CBT skills (i.e., motivational interviewing/consequence review, anger management skills, family safety planning and the abuse clarification letter) that are unique to parents who are responsible for the physical abuse experienced by the children, the particular CBT skills emphasized, the sequencing of skills and nuances of working with these parents that requires an additional set of therapy skills that are critically important to master. We believe that the learning collaborative approach, in fact, may be the best way to train in this model both for those with minimal CBT experience as well as those who have a CBT background and/or training in TF-CBT. A learning collaborative that incorporates didactic, experiential as well as consultation on your actual implementation of the model
allows the trainers to meet clinicians’ training needs at all levels, while also involving other professionals who will be critical to providing the needed support to direct service providers.

Sustaining Fidelity and Avoiding “Drift”

The Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network (2004) states that “Fidelity means that the clinician is using [the evidence based model] as it was designed and tested, in a consistent and clearly defined way. If clinicians diverge or “drift” too much from how the treatment was originally designed and tested, it may no longer be effective (pg. 35).”

The CPC-CBT Quality Assurance program is designed to provide CPC-CBT implementers with tools to assess the adherence of clinicians, supervisors, and organizations to CPC-CBT. Considerable time has been devoted to the development of quality assurance mechanisms aimed at enhancing CPC-CBT treatment fidelity as CPC-CBT may not be as effective if not delivered as intended. The program provides multiple levels of clinical and programmatic support and ongoing feedback from multiple sources to enhance clinical outcomes for families.

To enhance CPC-CBT treatment fidelity, feedback is obtained from clinicians, supervisors, and caregivers. Clinicians and supervisors submit monthly metrics to trainers about their CPC-CBT training cases including what assessment measures were administered, the number of sessions each family has received, and what treatment skills were offered. Clinicians also report on the amount of on-site supervision they were provided, what treatment skills were reviewed in supervision, and the helpfulness of the supervision. Supervisors report on the activities covered in the supervision they provided during the month including feedback regarding the supervisees’ implementation of CPC-CBT skills, engagement strategies, and managing crises while staying on track. Supervisors also report on the CPC-CBT skills used by supervisees as well as the supervisee’s skill level in implementing and/or teaching those skills. Families provide monthly feedback as well. The clinicians and supervisors submit monthly feedback regarding the case consultation on CPC-CBT implementation that is being provided by the trainers.

The following measures are used to monitor adherence to CPC-CBT:

- Monthly Metrics (including the CPC-CBT Adherence Checklist)
- Clinician Feedback Form
- Consultation Adherence Checklist

After clinicians have received training, the trainers will continue to provide ongoing consultation in the implementation of CPC-CBT to enhance treatment fidelity and assist them in balancing the clinical needs of participants and the treatment
How to Implement Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)

During consultation, activities of the previous session will be carefully reviewed, thereby allowing the consultants to provide feedback when drift occurs. Clinicians and their on-site supervisors will also be asked to complete monthly metrics that record the use of CPC-CBT skills with families. For smaller groups, consultants may also randomly select recordings of sessions with at least one client per clinician to review. The on-site clinical supervisors will also be learning to supervise CPC-CBT cases and will continue to provide CPC-CBT supervision to enhance fidelity after the training and consultation calls have ended. The monthly metrics and forms mentioned above that are used to track fidelity to CPC-CBT are included in Appendix D.

Creativity and flexibility are necessary when adapting the CPC-CBT model to best serve the needs of each individual child and family while maintaining fidelity to the underlying tenets and skills of CPC-CBT. It can be challenging for any clinician to strike a balance between fidelity to a particular treatment model and the needs of a client. However, some of the best manualized therapy occurs when a clinician is able to work collaboratively with a client to apply the model's agenda to the client's valid concerns. We are teaching skills that can be generalized to everyday life events and stressors. CPC-CBT contains many techniques and strategies that build on one another and flow from session to session. While it can be challenging to present all these concepts in one session, CPC-CBT is a highly structured, systematic approach that is outlined in a detailed treatment manual. It can be extremely challenging to introduce all concepts on an agenda if the session is not structured and the parent chooses to use the session to vent about his/her child's behavior or his/her child protection involvement. It is important to listen and validate those feelings, while simultaneously structuring the session by introducing a skill that can be utilized to manage a particular situation or one's reactions to the situation. It is important to assess the parents’ goals and to highlight how the treatment strategies can be useful in achieving those goals and to use the motivational/consequence review to motivate parents to be active participants.
Additional Clinical Considerations
VII. Additional Clinical Considerations

Benefits of Group vs. Individual

CPC-CBT can be delivered in an individual or group format. While no studies have directly compared group to individual CPC-CBT, there are specific therapeutic benefits that are associated with group and individual modalities in general. Indeed, the group treatment modality has specific therapeutic benefits. Researchers suggest that positive peer support among group members can increase families’ engagement with the program, attendance, and the shaping of parent behaviors (Borrego, Urquiza, Rasmussen, Zebell, 1999; Webster-Stratton & Hammond, 1997). In fact, 92% of parent participants in a study examining CPC-CBT indicated that the group helped them feel less alone. Holmes & Kivlighan (2000) identify group members as the primary source of change which is consistent with the belief that guarded populations, such as parents who engage in abusive behaviors towards their children, may benefit more from suggestions and interactions with their peers than from the therapist alone. This may be particularly true in the initial stages of therapy when the therapist is still building a therapeutic relationship and trust with parents. Group treatment provides parents with opportunities for socialization, feedback regarding socially appropriate behavior, and role-playing of desired peer and parent-child interactions. Group also provides opportunities for peer mediation, peer modeling and reinforcement, and leadership (Flannery-Schroeder, & Kendall, 2000).

Conversely, individual therapy may allow the therapist to tailor the treatment more to meet the individual families’ needs. For example, a therapist can elect to spend more time on parenting skills and less time on anger control skills in individual therapy based on the parent’s needs. In group treatment, equal time may be spent on both skills if one family in the group needs special attention to either of those areas. Individual therapy may be more beneficial for addressing symptoms for children as it allows more time for gradual exposure and processing of the traumatic experience and for assisting the parent in preparing and responding to the child in the abuse clarification letter.

CBT group interventions may have several advantages when compared to individual services. Group interventions are more cost-effective and allow child abuse programs across the nation to serve larger numbers of children and families thereby reducing the financial burden on our already overwhelmed CPS system. Moreover, group interventions can help to ensure that more families will have access to specialized, empirically-validated, abuse-focused treatment services. Group treatment may be particularly useful in urban areas with large numbers of clients and few staff whereas individual services may be more realistic and transportable to certain rural settings, such as private practices and community mental health centers.

Implementation: Multiple Traumas
The following important clinical considerations are summarized from an article by Runyon, Deblinger and Schroeder (2009).

Given the comorbidity between physical abuse, domestic violence, and sexual abuse, in the children in studies examining CPC-CBT and other studies reported, clinicians should be mindful that CPC-CBT is not appropriate in cases where the parent is the perpetrator of both the sexual abuse and physical abuse.

In cases where the child does not continue to reside with the perpetrator of the sexual abuse, it is appropriate to deal with multiple traumas in the context of CPC-CBT. All types of abuse (i.e., physical, emotional, and sexual) are covered in the psychoeducation skill of CPC-CBT. Clinicians may incorporate individualized homework assignments and joint activities to address child sexual abuse, such as having parents read a book to their children about body safety skills training (e.g., Stauffer & Deblinger, 2003). Domestic violence should be assessed very carefully and depending on the parent's fear for their safety and the severity of violence reported, CPC-CBT may not be appropriate for the family. If there is a significant degree of partner violence and the battered individual expresses discomfort in attending therapy sessions with his/her partner, the treatment of choice is likely to begin by referring the batterer to a batterer's program before offering CPC-CBT to the family. During the assessment, the batterer, battered individual and child(ren) should be interviewed separately to assess if they provide similar descriptions of the incidents of and level of domestic violence as well as when the last incident occurred. If their descriptions of violence are similar, the level of violence is low, and the battered individual is comfortable, then a family may be offered CPC-CBT. In cases involving multiple traumas, children may describe scenarios depicting separate episodes of the different types of abuse (i.e., physical and/or sexual abuse, exposure to violence) when they are developing their abuse narrative and processing related thoughts and feeling. This gives the child an opportunity to process multiple traumatic experiences. In some instances, both parents, the one who engages in the abusive behavior toward the child as well as the parent who engaged in domestic violence, participate in CPC-CBT and are able to respond to the child's fears related to both the physical abuse and domestic violence.

Implementation: A Wide Range of Developmental Levels

Whether offering CPC-CBT in an individual or group format, clinicians should attempt to accommodate a wide developmental range. If there are siblings from a wide age range in a group, each clinician can tailor the presentation to a smaller subset of the group in the same room. In fact, the older subgroup may then assist the group facilitator in teaching a particular skill to the younger subgroup, which appears to enhance their self-esteem. Then, all child participants role-play scenarios and practice skills. Having a diverse age group of participants may enhance the ability for all members to generalize learned skills given that children may have to use learned skills in real-life situations with individuals outside their age group. When this is not possible due to having one child who is much older or younger than the rest of the...
group members, this child may receive parallel individual therapy while siblings are in group. This child can then be incorporated into the joint meetings with his/her siblings and parent(s). Another option is to provide CPC-CBT in an individual format which can eliminate the clinical concern of working with children of a wide age and developmental range all together.

When providing individual therapy, it is important to make adjustments to the model to meet the developmental needs of the individual child. In general, it is useful when working with children and adolescents to adapt questions to reflect their developmental level. Psychoeducation is an example where terms such as emotional abuse may need to be adapted. For example, young children understand feelings abuse as words that hurt your feelings. Specific therapeutic skills geared towards the children, should also be tailored towards their developmental level. Incorporating fun activities to teach skills can be helpful in engaging young children and older children alike in the therapy process. There are a number of therapeutic books and games that teach children cognitive coping, assertiveness, and anger management skills. Therapeutic books, such as, Helping Families Heal: A Story about Child Physical Abuse (Runyon, Cooper, & Glickman, 2007) can be read to children in an effort to provide psychoeducation about CPA and to prepare them for developing a trauma narrative about their abusive experiences. For instance, The Mouse, the Monster, and Me is a great metaphor to use to introduce and assist in distinguishing between the concepts of passive, aggressive, and assertive behavior respectively that introduces fun to the therapy process. Repetitive behavioral rehearsal of skills with personalized situations can also assist children in incorporating new skills into their behavioral repertoire.

The involvement in treatment of all caregivers in the household is encouraged to offer support and psychoeducation about abuse and trauma, to assist parents in co-parenting as a cohesive team, and to strengthen family relationships through the use of communication and behavioral skills.

Implementation: Processing Abuse with Children Who Have Ongoing Contact with the Perpetrator of Physical Abuse

Trauma-focused models, like TF-CBT that was co-developed by the CPC-CBT co-developer, typically begin gradual exposure around the child’s trauma early in the treatment process given that, in appropriate cases, the child is no longer having unsupervised contact with the perpetrator. The trauma narrative, a skill where abuse-related fears or anxiety are extinguished over time through repeated gradual exposure and processing, is an integral part of the gradual exposure process for both TF-CBT and CPC-CBT, but the timing of this skill differs for the two models. It is important in CPC-CBT to delay the development of the trauma narrative and clarification process to the last stage of treatment after it has been noted that the parent has demonstrated some improvement in modulating his/her emotions, controlling his/her anger, utilizing positive and nonviolent parenting strategies to
discipline the child, and positive parent-child interactions. To assess readiness, clinicians assess whether the child also reports an increased sense of safety at home and positive interactions with his/her parents. At this stage of therapy if these goals have been accomplished, children will be better able to discuss the details of their abuse and process their feelings and thoughts as they are feeling safer in the home environment.
Conclusions
VIII. Conclusions

CPC-CBT is an effective treatment for families where parents engage in a continuum of coercive parenting strategies ranging from those who are extremely stressed and fear they will lose control with their children to those who have been substantiated for physical abuse by CPS. Not only does CPC-CBT empower parents to effectively parent their children in a non-violent manner, it also strengthens family relationships and assists children in healing from the trauma of the physical abuse. While CPC-CBT is effective, it may not be right for all practice settings. This manual offers information to address some of the questions that may arise for professionals and agencies when considering whether and how to implement CPC-CBT. To learn more about the implementation of CPC-CBT, contact Noelle Davis at davisno@umdnj.edu.
References
IX. References


X. Appendices

Appendix A: Relevant Studies
Appendix B: Recommended Materials
Appendix C: Recommended Measures
Appendix D: Client Handouts & Form to obtain referral incident statement.
Appendix E: Learning Collaborative Forms
Appendix A: Relevant Studies


Appendix B: Recommended Materials

Below is a list of recommended materials, the developers of CPC-CBT have highlighted the list of books that are the most readily available to clinicians working with this population or those that may be the most helpful with the implementation of CPC-CBT.

BOOKS FOR PARENTS: BEHAVIOR MANAGEMENT

Off road parenting: Practical solutions for difficult behavior (CD-Rom included)
Author: Caesar Pacifici, Patricia Chamberlain, & Lee White
Publisher: Northwest Media
ISBN#: 1-892194-25-2

SOS help for emotions: Managing anxiety, anger, & depression
Author: Lynn Clark
Publisher: Parents Press
ISBN#: 0-935111-50-6

Parents and adolescents, part 1: The basics
Author: Gerald Patterson & Marion Forgatch
Publisher: Research Press
ISBN#: 0-87822-516-1

“The answer is no” saying It and sticking to It
Author: Cynthia Whitman
Publisher: Perspective Publishing (1994)
ISBN#: 0-96220360405

Positive parenting from A to Z
Author: Karen Renshaw Joslin
Publisher: Fawcett Columbine/Ballantine Books
ISBN#: 0-449-90780-5

Time-in: When time-out doesn’t work
Author: Jean Illsley Clark
Publisher: Parenting Press, Inc.
ISBN#: 1-884734-28-6

CHILDREN’S BOOKS

All About Adoption: How Families are Made
Author: Marc Nemiroff and Jane Annunziate
Publisher: Magination Press
ISBN#: 1591470595

The feel good book
Author: Todd Parr
Publisher: Little, Brown & Company
ISBN#: 0-316-07206-0

Everybody Gets Angry
Author: Ellen Pitt
Publisher: The Bureau for At-Risk Youth

Finding the Right Spot: When Kids Can’t Live with Their Parents
Author: Janice Levy and Whitney Martin
Publisher: Magination Press
ISBN#: 1591470749

Every Time I Blow My Top I Lose My Head
Author: Laura Slap-Shelton/Laurence Shapiro
Publisher: Childswork/Childsplay

Hands are Not for Hitting
Author: Martine Agassi and Marieka Heinlen
Publisher: Free Sprit Press
ISBN#: 1575420775

The family book
Author: Todd Parr
Publisher: Little, Brown & Company
ISBN#: 0-316-73896-4
Helping families heal: A story about child physical abuse
Authors: Melissa Runyon et al.
Publisher: CARES Institute
caretraining@umdnj.edu

It’s okay to be different
Author: Todd Parr
Publisher: Little, Brown & Company
ISBN#: 0-316-66603-3

The Magic Box: When Parents Can’t Be There to Tuck You In
Author: Marty Sederman, Karen S. Brooks (Illustrator), Seymour Epstein
Publisher: Magination Press
ISBN#: 1557988072

Maybe days: A book for children in foster care
Authors: Jennifer Wilgocki & Kahn Wright
Publisher: Magination Press
ISBN#: 1-55798-802-1

My Mom and Dad Don’t Live Together Anymore: A Drawing Book
Author: Judith Ruben
Publisher: Magination Press
ISBN#: 1557988358

My Mouth is A Volcano
Author: Julia Cook and Carrie Hartman
Publisher: CTC Publishing
ISBN#: 0974778974

The Mouse, the Monster, and Me: Assertiveness for Young People
Author: Pat Palmer

Sometimes I Like to Fight, But I Don’t Do It Much Anymore
Author: Laurence Shapiro
Publisher: Childswork/Childsplay
ISBN#: 1882732227

Teeth are Not for Biting
Author: Elizabeth Verdick and Marieka Heinlen
Publisher: Free Sprit Press
ISBN#: 1575421283

When You’re Happy and You Know It
Author: Elizabeth Crary, Mits Katayama (Illustrator),
Publisher: Parenting Press
ISBN#: 1884734103

When You’re Mad and You Know It,
Author: Elizabeth Crary, Mits Katayama (Illustrator),
Publisher: Parenting Press
ISBN#: 188473411

When You’re Shy and You Know It
Author: Elizabeth Crary, Mits Katayama (Illustrator),
Publisher: Parenting Press
ISBN#: 1884734138

When You’re Silly and You Know It
Author: Elizabeth Crary, Mits Katayama (Illustrator),
Publisher: Parenting Press
ISBN#: 1884734138

EMOTIONAL EXPRESSION AND IDENTIFICATION

Sad isn’t bad
Author: Michaelene Mundy
Publisher: One Caring Place/Abbey Press
ISBN#: 0-87029-321-4

Today I feel silly and other moods that make my day
Author: Jamie Lee Curtis
Publisher: Harper Collins
ISBN#: 0-06-024560-3

Helping families heal: A story about child physical abuse
Authors: Melissa Runyon et al.
Publisher: CARES Institute
caretraining@umdnj.edu

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Publisher: Little, Brown & Company
ISBN#: 0-316-66603-3

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Today I feel silly and other moods that make my day
Author: Jamie Lee Curtis
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### COPING

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<td><strong>A volcano in my tummy</strong></td>
<td>Elaine Whitehouse/Warwick Pudney</td>
<td>New Society Publishers</td>
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<td><strong>Blue cheese breath and stinky feet: How to deal with bullies</strong></td>
<td>Catherine DePino</td>
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<td><strong>Don’t be a menace on Sundays: The children’s anti-violence book</strong></td>
<td>Adolph Moser</td>
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<td><strong>Don’t hurt me Mamma</strong></td>
<td>Muriel Stanek</td>
<td>Albert Whitman &amp; Company</td>
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<td><strong>How to take the grrrr out of anger</strong></td>
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<td>Marla Sobel</td>
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<td>Marcia Shoshanna Nass</td>
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### GAMES

**What Do You Know?**
Author/Developer: Esther Deblinger, Felicia Neubauer, Melissa Runyon & Donyale Baker
Publisher: CARES Institute
carestraining@umdnj.edu

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<td>The Peace Path Game</td>
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<tr>
<td><a href="http://www.childswork.com">www.childswork.com</a></td>
<td>Author: Lisa Marie Barden</td>
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<tr>
<td>The Empathy Game</td>
<td>Publisher: WPS Creative Therapy Stores</td>
</tr>
<tr>
<td>Author/Developer: Lawrence Shapiro</td>
<td>Stop, Relax, and Think Game</td>
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<td><a href="http://www.childswork.com">www.childswork.com</a></td>
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<tr>
<td>Face Your Feelings Set</td>
<td>Thoughts &amp; Feelings Card Game</td>
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<tr>
<td>Publisher: Childswork/Childsplay</td>
<td>Author: Lisa Marie Arneson</td>
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<td>Feelings Cards</td>
<td>Publisher: Bright Spots Games</td>
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<tr>
<td>Author/Developer: Michele Kiblar</td>
<td><a href="http://www.BrightSpotsGames.com">www.BrightSpotsGames.com</a></td>
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<tr>
<td>Publisher: Kidsrights</td>
<td>The You and Me Social Skills Collection</td>
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<td><a href="http://www.childswork.com">www.childswork.com</a></td>
<td>Author: Lawrence Shapiro</td>
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<td>Feelings Fair</td>
<td>The Talking, Feeling, &amp; Doing Game</td>
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<td>Publisher: Franklin Learning Systems</td>
<td>Author/Developer: Richard A. Gardner</td>
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<td>Publisher: Childswork/Childsplay</td>
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<td>The You and Me Social Skills Collection</td>
<td>The Talking, Feeling, &amp; Doing Game</td>
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<td>The Talking, Feeling, &amp; Doing Game</td>
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<td>Distributor: White Noise Productions</td>
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<td><a href="http://www.BrightSpotsGames.com">www.BrightSpotsGames.com</a></td>
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### VIDEOS FOR CHILDREN

- Feelings and Faces – Feelings Awareness
- Fun to Share – Conflict Resolution
- Happy to Be Me: Self-Respect
- Mad Me: Anger Management

### VIDEOS FOR PARENTS

- All distributed by Bolden Publishing
- www.bouldenpublishing.com
Shaking, hitting, spanking: What to do instead
Publisher: Gold Bell Productions
www.childdevelopmentmedia.com

Yelling, threatening, & putting down: What to do instead
Publisher: Gold Bell Productions
www.childdevelopmentmedia.com

SPANISH LANGUAGE RESOURCES

Amor & Limites
Author: Elizabeth Crary
Publisher: Parenting Press
ISBN#: 1884734510

Bright spots: thoughts and feelings card game
Author/Developer: Lisa Marie Arneson
Publisher: Bright Spots Games
www.brightspotgames.com

Fernando furioso
Author: Hiawyn Oram
Publisher: Ediciones Ekare
ISBN#: 9802570613

Gana la guerra de los berrinches y otras contiendas: Un plan de paz familiar
Author: Cynthia Whitman
Publisher: Perspective Publishing
ISBN#: 1-930085-04-4

La Respuesta es No

BOOKS FOR THERAPIST

Assessing and treating physically abused children and their families: A cognitive-behavioral approach
Author: David Kolko & Cynthia Cupit Swenson
Publisher: Sage Publications
ISBN#: 0761921494

Therapeutic Groupwork with Children
Author: Joost Drost and Sydney Bayley
Publisher: Speechmark Publishing Ltd.
ISBN#: 0-86388-234-X

Stickin' to, watchin' over, and getting' with: An African American parent’s guide to discipline
Author: Howard C. Stevenson, Gwendolyn Davis & Saburah Abdul-Kabir
Publisher: Jossey-Bass
ISBN#: 078795702X

How to Implement Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT)
64
Appendix C: Recommended Measures

- APQ is available by contacting: Paul J. Frick, Ph.D., Research Professor, Director, Applied Developmental Program, Department of Psychology, University of New Orleans, 2001 Geology & Psychology Bldg., New Orleans, LA 70148, Ph: 504-280-6012 Fax: 504-280-6049, e-mail: pfrick@uno.edu, web: http://www.uno.edu/~psyc/labpage.html

- BDI-II is available from Pearson (www.pearsonassess.com)

- CBCL is available from ASEBA (www.ASEBA.org)

- CDI is available from MHS assessment (www.MHS.com)

- CTS is available from Western Psychological Services (www.wpspublish.com)

- PAI is available by contacting: David Hanson, University of Nebraska-Lincoln, email: dhansen1@unl.edu

- PTSD-RI is available by contacting: Alan M. Steinberg, Ph.D., Associate Director, National Center for Child Traumatic Stress, Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles, 11150 West Olympic Boulevard, Suite 650, Los Angeles, CA 90064, Ph: 310-235-2633 Ext. 224, e-mail: ASteinberg@mednet.ucla.edu

- SDQ is available at http://www.sdqinfo.org/
Appendix D: Client Handouts
Guidelines for Use of Metrics for Tracking Improvements in the Implementation of CPC-CBT

As mentioned in the CPC-CBT Implementation Manual (Runyon & Deblinger, 2010), the National Child Traumatic Stress Network’s Learning Collaborative toolkit is used as a guide for training in the implementation of CPC-CBT. CPC-CBT faculty uses the toolkit as the format for informing CPC-CBT trainings. According to the authors of the toolkit, Markiewicz, Ebert, Ling, Amaya-Jackson, & Kisiel (2006), “the ability for an agency to measure progress and performance is crucial in the process of learning, implementing, and sustaining a new practice. Measurement plays an important role in evaluating how well collaborative activities are supporting implementation and adoption efforts and in ensuring that the collaborative meets its objectives. (Module 4, p. 90)”

The developers and training faculty of CPC-CBT have adopted the use of metrics to assist training participants in tracking improvements associated with the implementation of CPC-CBT in their organizations. During training sessions, CPC-CBT faculty/trainers closely link metrics and measures to the Collaborative Goals as stated in the Learning Collaborative Change package.

Training participants are informed that the metrics are critical to evaluate their progress toward the Collaborative Goals. Measures are important to: 1) determine if the changes teams are testing (e.g., small tests of change) result in improvements, 2) refine changes and focus the team’s efforts on areas and goals most needed for successful implementation of CPC-CBT, and 3) measure progress over time that is critical to sustaining CPC-CBT.

Below are some examples of goals that are provided to training participants to assist them in linking collaborative goals to metrics. Teams from each organization are asked to establish goals in the areas mentioned below across the training sessions in order to monitor progress in the Implementation of CPC-CBT at their organization. Faculty provides team members with a summary of the monthly metrics on a monthly basis so they can evaluate their organization’s progress towards these goals. Through phone consultation with senior leaders supervisors and and faculty members, CPC-CBT faculty assist leaders in evaluating and celebrating progress towards goals as well as setting new goals to help move their organization towards meeting goals, if necessary.

**Assessment**

- **General Goal:** Children referred for psychotherapy are screened for referral to CPC-CBT using a protocol that incorporates standardized assessments.

- **Specific Measurable Goal:** By December 2006, 80% of all children age 7 or older who are referred for psychotherapy will be screened for referral to Combined Parent Child Cognitive Behavioral Therapy (CPC-CBT) using a protocol that
incorporates standardized assessments (as outlined in the CPC-CBT Implementation Manual) to screen child trauma history, trauma symptoms, and coercive parenting strategies.

☞ **Sample Metric:** Percentage of children age 7 or older and parents who had a psychotherapy intake during the past month who were screened for CPC-CBT using the standardized CPC-CBT screener and assessment protocol.

**Fidelity**

☞ **General Goal:** Clinicians who provide CPC-CBT will implement the model with adequate fidelity.

☞ **Specific Measurable Goal:** By November, 2007 clinicians providing CPC-CBT will consistently administer all CPC-CBT Skills as outlined in the monthly metrics, unless clinically contraindicated.

☞ **Sample Metric:** Percentage of clinicians currently providing CPC-CBT who “Almost Always” implemented all CPC-CBT Skills, based on clinician self report supervisor report.

**Training**

☞ **General Goal:** Agency staff who provide psychotherapy to traumatized children and parents at-risk for child physical abuse receive basic training in CPC-CBT.

☞ **Specific Measurable Goal:** By December 2006, 90% of agency staff who provide psychotherapy to traumatized children and parents at-risk for physical abuse will have attended a basic training in CPC-CBT.

☞ **Sample Metric:** Percentage of staff providing psychotherapy to traumatized children and parents at-risk for physical therapy who have completed basic training in CPC-CBT (i.e., attended a two-day in-person training) as documented in their monthly metrics.

**Supervision**

☞ **General Goal:** Clinicians who provide CPC-CBT receive ongoing supervision in the model.

☞ **Specific Measurable Goal:** By December 2006, clinicians who are currently providing CPC-CBT will receive a minimum of two hours of supervision in CPC-CBT per month. A combination of group supervision, individual supervision, and expert consultation can be used to fulfill this requirement.
Sample Metric: Percentage of clinicians with an open CPC-CBT case who reported receiving at least two hours of supervision in CPC-CBT during the past month as reported on the monthly metrics.

Please refer to the Screening and assessment section of the CPC-CBT Implementation Manual (Runyon, & Deblinger, 2010) for guidelines for the use of standardized measures to assist trainees in screening and identifying appropriate CPC-CBT clients as well as monitoring client progress across therapy.

References
