

**Combined
Parent-Child
Cognitive
Behavioral
Therapy (CPC-
CBT): Training
Brochure**

WHAT IS COMBINED PARENT-CHILD COGNITIVE BEHAVIORAL THERAPY?

Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT), an evidence-based treatment (EBT) designed to address the needs of children and families at-risk for child physical abuse, was developed by Melissa K. Runyon, PhD in collaboration with Esther Deblinger, PhD. CPC-CBT and has been identified as a promising practice by the National Child Traumatic Stress Network (NCTSN) and has been included on the federal government's National Registry of Evidence-Based Programs and Practices (NREPP) and the California Evidence-based Clearinghouse for Child Welfare (CEBC) websites.

HISTORY OF DEVELOPMENT OF COMBINED PARENT-CHILD COGNITIVE BEHAVIORAL THERAPY

In cases of child physical abuse, 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 that inadvertently neglect 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 was warranted. CPC-CBT is a structured EBT for children ages 3-17 and their parents (or caregivers) in families where parents engage in a continuum of coercive parenting strategies. CPC-CBT

is designed not only for families where physical abuse has been substantiated, but also as preventative with cases where families are considered at-risk of physical abuse occurring. 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 discipline 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 needs. The program aims to reduce children's posttraumatic stress disorder (PTSD) symptoms, other internalizing symptoms, and behavior problems while improving parenting skills and parent-child relationships and reducing the use of corporal punishment by parents.

PROGRAM DESCRIPTION COMBINED PARENT-CHILD COGNITIVE BEHAVIORAL THERAPY

CPC-CBT is a structured, EBT that consists of parent interventions, child interventions, and family interventions CPC-CBT is grounded in cognitive behavioral theory and incorporates elements (e.g., trauma narrative and processing, positive reinforcement, timeout, behavioral contracting) from CBT models for families who have experienced sexual abuse, physical abuse, and/or domestic violence, as well as elements from motivational, family systems, trauma, and developmental theories. CPC-CBT can be offered in either individual (90-minute sessions) or group (2-hour sessions) in 16-20 sessions across four phases: Engagement, Coping Skill Building, Family Safety, and Abuse Clarification.

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.

In the simplest terms, CPC-CBT clinicians are helping parents to create positive family environments, to enjoy their children, and to enjoy being parents. 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.

Some of the components and skills offered during structured therapy sessions across the four phases are described below:

Phase 1: Engagement & Psychoeducation

- Engaging and motivating parents who are often not contemplating changing their parenting style or interactions with their children by using the following techniques:
 - Engagement strategies
 - Motivational Interviewing/consequence review
 - Individualized goal setting

- Providing violence psychoeducation including educating both parents and children on:
 - Different types of violence
 - The continuum of coercive behavior
 - The impact of violent behavior on children

- Providing psychoeducation for parents about:
 - Child development
 - Realistic expectations for children's behavior.

- Addressing parental history of trauma exposure including its impact on:
 - Their relationships with their parents
 - Their parenting approach with their own children.

Phase 2: Effective Coping Skill Building

- Empowering parents to be effective by working collaboratively with them to:
 - Develop adaptive coping skills
 - Cognitive coping
 - Anger management
 - Relaxation
 - Assertiveness
 - Self-care
 - Problem solving
 - Assist them in remaining calm while interacting with their children.
 - Develop non-violent conflict resolution skills.
 - Develop a variety of problem-solving skills related to child rearing.
 - Develop a variety of non-coercive child behavior management skills.
 - Learn the dynamics of their interactions with their children and what escalates anger and violence during these interactions and how to use skills to diffuse the situation.

Phase 3: Family Safety

- Developing a family safety plan that involves:
 - Learning how to identify when parent-child interactions are escalating.
 - Taking a cool down period in order to enhance safety and communication in the family.

- Having parents and children rehearse the implementation of the family safety plan.
- Introducing other safety components across the therapy.

Phase 4: Abuse Clarification

- Clarification involves the parent writing an abuse clarification letter and the child developing a trauma narrative about the abuse experienced.
- Specifically, the clinician encourages the children to write about or share their abusive experiences while focusing on their thoughts and feelings associated with the abuse.
- While the child is developing this trauma narrative, the clinician also assists parents in processing their own thoughts and feelings while writing and revising a "clarification" letter to their children to enhance their empathy for their children and to demonstrate that they take full responsibility for their abusive behavior.
- The clarification letter also serves to:
 - Alleviate the child of blame.
 - Respond to the child's questions and/or worries.
 - Correct the child's cognitive distortions concerning the abuse.
 - The parents and children share the clarification letter and trauma narrative in joint segments, unless this process is contraindicated. However, in most cases, this process enhances the parent's empathy for the child and is a powerful therapeutic tool for strengthening the parent-child relationship. CPC-CBT is the only treatment involving at-risk parents that incorporates the trauma narrative into the clarification process.

Parenting Skills Training

- ❑ Parenting skills training is provided across all phases:
- ❑ The therapists help 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 first with the therapist and then with children while the clinicians coach them by offering positive reinforcement and corrective feedback to enhance the skills.

APPROPRIATE REFERRALS FOR COMBINED PARENT-CHILD COGNITIVE BEHAVIORAL THERAPY

Children (ages 3-17) and their caregivers who are at-risk for or who have who have already engaged in physically abusive behavior towards their children are appropriate CPC-CBT referrals. At-risk may be defined as those families who have had multiple referrals to CPS with no substantiation, as well as those families who report using excessive physical punishment and coercive parenting strategies 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.

HOW EFFECTIVE IS COMBINED PARENT-CHILD COGNITIVE BEHAVIORAL THERAPY?

The outcomes of multiple studies have supported CPC-CBT for reducing the use of physical punishment and parental distress, as

well as improving positive parenting skills and children's emotional and behavioral functioning.

A small pilot study compared children's and parents' functioning prior to initiating treatment to their functioning after completing a 16-session course of group CPC-CBT. After their participation in CPC-CBT, parents and children reported significant reductions in the use of physical punishment, reductions in parental anger toward their children, as well as improvements in consistent parenting, children's PTSD symptoms, and behavioral problems (Runyon, Deblinger & Schroeder, 2009).

In a randomized controlled study, CPC-CBT (Runyon, Deblinger & Steer, 2010) was compared to CBT for the parent alone. CPC-CBT involving both the child and parent was associated with greater improvements in positive parenting skills and children's PTSD. Therapists are encouraged to put a great deal of energy into the initial engagement sessions involving the disclosure of the referral incident, motivational interviewing and commitment to no violence, with caregivers presenting for CPC-CBT. In fact, in the study described above, only 12 % of participants dropped out after completing the two initial engagement sessions. However, many families dropped out prior to initiating treatment. As such, evidence-engagement strategies implemented over the phone prior to the initial appointments have been used in conjunction with the CPC-CBT engagement sessions to enhance attendance rates to the initial sessions.

To examine outcomes associated with individual CPC-CBT, a pilot study compared children's and parents' functioning prior to initiating treatment to their functioning after completing individual CPC-CBT. After their participation in CPC-CBT, children reported significant reductions in depressive symptoms while parents reported improvements in their levels of depression, consistent parenting, and children's externalizing behavior problems (Runyon, Deblinger & Schroeder, in preparation). Both children and parents reported significant reductions in the use of corporal punishment.

To further enhance engagement, the developers of CPC-CBT has attempted to increase the cultural sensitivity of the treatment and associated materials. For instance, the culturally relevant materials currently used in CPC-CBT were integrated based on consumers who participated in the initial comparison study - 75% of participating families who provided feedback identified themselves as being a member of a group that would be defined as an ethnic minority.

CPC-CBT has also been evaluated in mental health centers and social service units in the United States and Sweden. Four child protection and child and adolescent psychiatry social service units across Sweden (Kristianstad, Linköping, Lund and Malmö) were trained by the developer in CPC-CBT. As part of this dissemination project, researchers conducted a pilot study with a majority of participants receiving individual CPC-CBT (Kjellgren, Svedin, & Nilsson, 2013). After their participation in CPC-CBT, parents (n=26) reported a significant decrease in depression, violent parenting tactics, and inconsistent parenting, and children's trauma symptoms, and children (n=25) reported significant improvements in trauma and depressive symptoms. Children also reported significant decreases in coercive parenting tactics and improvements in positive parenting for their parents. The authors concluded that CPC-CBT was applicable and effective for treating CPA in Sweden that is defined as a much lower threshold of coercion than in the United States.

Researchers are currently conducting a clinical trial comparing CPC-CBT to treatment as usual in Sweden. In the first phase of the study, Kjellgren, Nilsson, and colleagues examined pre to post-treatment changes and 6-month follow-up data for caregivers and children and documented outcomes similar to those in the other CPC-CBT studies mentioned above. The Swedish researchers are collecting comparison data from families who received treatment as usual in Sweden. In a secondary study conducted by Johanna Thulin, a doctoral student, and her colleagues, Ms. Thulin interviewed children about their perceptions of CPC-CBT. The preliminary qualitative data suggests that children perceive CPC-CBT as having a very positive impact on their families and that

they perceive the Abuse Clarification process (trauma narrative and processing and clarification letter) as an important and powerful aspect of the treatment. These preliminary findings were shared during a conference presentation (Runyon, Kjellgren, Nilsson, & Thulin, 2017, February). Published reports of final reports of this project are forthcoming.

In another dissemination project, three agencies in Mississippi were trained in CPC-CBT using the National Child Traumatic Stress Network's Learning Collaborative (LC) framework. While a small group of clinicians (12 clinicians) from these agencies were trained and actively providing CPC-CBT to families, pre and post training data revealed significant changes in organizational practices, practices, clinicians' practices, and clinical outcomes for families. The families who received CPC-CBT over the course of the LC reported significant improvements in parenting and reductions in the use of corporal from pre-to post-treatment. Participating clinicians also reported significant increases in the use of a number of CPC-CBT components and skills during parent, child, and joint sessions after their participation in the LC.

DISSEMINATION OF COMBINED PARENT-CHILD COGNITIVE BEHAVIORAL THERAPY?

CPC-CBT has been disseminated to a number of agencies in the United States and in Sweden. In Sweden, Dr. Runyon trained therapists from four agencies across the Southern portion of the country. Five therapists from the original group participated in the CPC-CBT Train-The-Trainers program and have now trained more than 100 therapists from multiple sites in Sweden. Staff at a number of locations across the United States have received training and consultation in CPC-CBT including the Center for Child and Family Health at Duke University Medical Center in North Carolina, the Children's Center in Utah, Nurturing Family Center in Kentucky, Community Mental Health Centers in Mississippi, Oregon, Singapore, Australia, and Heartland for Children in Florida.

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:

1. build evidence-based knowledge and practice skills concerning CPC-CBT,
2. implement, use, and practice those skills on a daily basis with clients,
3. receive expert consultation concerning the cases they are seeing,
4. measure their progress over time,
5. sustain the use of CPC-CBT in their organization and community long after the training and consultation services have been completed, and
6. provide clinicians with an opportunity to work with LC members to identify and overcome barriers to families receiving CPC-CBT in their community.

There are some recommended prerequisites to CPC-CBT training regardless of the training package selected. Engagement is a critical component to working with the physical abuse population where parents are often reluctant to participate in therapy and may be hesitant to change their parenting behavior and interactions with their children. As such, training in evidence-based engagement strategies to increase attendance to initial treatment appointment and ongoing participation in treatment is highly recommended. Motivational interviewing is an important skill for the CPC-CBT therapist to use to motivate parents and youth, in some instances, to change behavior. Motivational interviewing and theory is woven throughout CPC-CBT. Since it is not possible to review the underlying tenets of motivational interviewing in the CPC-CBT training, it is highly recommended

that participating therapists attend a basic motivational interviewing course/workshop (on-line or in-person).

Training packages are provided in evidence-based engagement strategies to increase the likelihood that children and families involved in the child welfare system seek services, attend initial intake appointments and follow through with services.

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 LC which consists of pre-work, three 2-day in-person learning sessions spaced over the course of eight to twelve months with 12 consultation calls with clinicians in the implementation of CPC-CBT occurring twice per month between the learning sessions and calls with leadership and supervisors to promote sustainability of CPC-CBT. To learn more about the LC training methodology and requirements, please refer to the LC Implementation Manual (Markiewicz, Ebert, Ling, Amaya-Jackson, & Kisel, 2006) on the National Child Traumatic Stress website (NCTSN.org).

Many agencies opt for the second training option that incorporates some of the LC methodology but is relatively less intensive. This involves three full days of in-person introductory training on the model that includes role-plays and performance feedback. Because the program is highly structured, ongoing consultation that occurs twice per month (12 calls) for at least one full cycle of therapy is recommended for clinicians as well. Feedback on audio taped client sessions is highly recommended.

Calls are also conducted with leadership and supervisors to address system barriers and support the development of agency protocols that promote sustainability of CPC-CBT in the organization. Two days of advanced training is offered after the initial training sessions to address advanced concepts and questions that arise after clinicians have implemented the model with 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 a one-day informational training in the model that includes role-plays and performance feedback. However, agencies should not expect staff to be able to fully implement CPC-CBT after a one-day training event. If after participating in the informational 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.

Consultation packages are available to assist leaders in agencies in training and sustaining evidence-based therapies in their organizations

Consultation packages are available to assist states, systems or organizations in establishing trauma-informed systems of care to meet the needs of children and families involved in the child welfare system.

There is also a CPC-CBT Train-the-Trainers training package available for agencies, systems, or countries with a desire to continue to disseminate CPC-CBT long-term. For example, 5 trainers were trained in Sweden and the Swedish trainers have trained over 100 therapists at 13 agencies across Sweden in CPC-CBT.

For more information regarding fees and training in CPC-CBT, contact Melissa K. Runyon, PhD at 609-247-5273 or MelissaRunyonPhD@gmail.com.

To learn more about CPC-CBT, visit the websites below:

<http://www.cebc4cw.org/program/combined-parent-child->

[cognitive-behavioral-therapy-cpc-cbt/](#)

http://www.nctsnet.org/sites/default/files/assets/pdfs/CPCCBT_General.pdf

<http://www.nrepp.samhsa.gov>

The CPC-CBT treatment manual may be obtained from Oxford University Press: Runyon, M. K., & Deblinger, E. (2014). Combined Parent-Child Cognitive Behavioral Therapy (CPC-CBT): An Approach to Empower Families At-Risk for Child Physical Abuse. New York, NY: Oxford University Press. To obtain book, go to <https://global.oup.com/academic/product/combined-parent-child-cognitive-behavioral-therapy-9780199916887?cc=us&lang=en&>

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