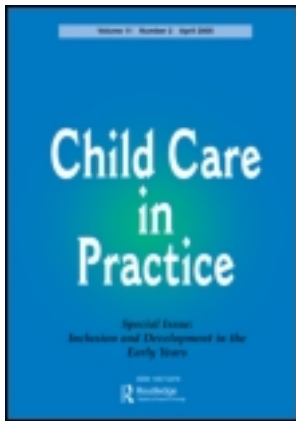


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Child Physical Abuse—Experiences of Combined Treatment for Children and their Parents: A Pilot Study

Cecilia Kjellgren, Carl Göran Svedin & Doris Nilsson

This paper reports on the results of treatment for families where child physical abuse has occurred. The Combined Parent–Child Cognitive–Behavioral Therapy for Families at Risk for Child Physical Abuse (CPC-CBT) model includes parent and child interventions. Four teams (within child protection and child and adolescent psychiatry services, based in Sweden) were trained to run the treatment. CPC-CBT is a 16-session programme where children and parents receive treatment in parallel groups and joint family sessions. A pilot study, with pre and post measures for both children and parents, was carried out to evaluate the treatment effects (18 families, 26 adults and 25 children). Significantly decreased symptoms of depression among parents, less use of violent parenting strategies and less inconsistent parenting were reported after treatment. Children initially reported high levels of traumatic experiences and symptoms of post-traumatic stress disorder. After treatment, trauma symptoms and depression among children were significantly reduced. Children also reported that parents used significantly less violence and increased positive parenting strategies after completion of the treatment. The implications of the findings are discussed.

Introduction

Researchers and clinicians clearly distinguish between physical abuse and corporal punishment, in the context of upbringing (Appleton & Stanley, 2011; Zolotor, Theodore, Chang, & Laskey, 2011). Physical abuse is forbidden in almost every country, and the United Nations' Convention on the Rights of the Child states that:

States and parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental

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violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. (United Nations, 1989, article 19:1)

Almost all countries, with the exception of the United States and Somalia, have ratified the Convention. When it comes to corporal punishment, only 29 countries have prohibited the use of corporal punishment in all contexts. Accordingly, in most countries corporal punishment is allowed as long as it is carried out for the purposes of the upbringing of a child and as long as it does not cause injury. In Sweden, corporal punishment has been forbidden by law since 1979 and there is broad agreement among parents in Sweden that it is wrong to physically punish a child (Janson, Jernbro, & Långberg, 2011). However, according to police reports concerning the physical abuse of children in Sweden, there has been an increase in the last decade (Janson et al., 2011). The reason for this increase is still not known. It could be an actual increase or that people are more inclined to report suspected child abuse. It is mandatory for professionals in Sweden to report any suspected child abuse to the child protection services.

Since corporal punishment can easily escalate into physical abuse (Ateah, Secco, & Woodgate, 2003; Crouch & Behl, 2001), early intervention and the provision of early adequate treatment is important so that the negative spiral can be broken (Kassam-Addams & Fein, 2003; Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011). The physical abuse of children has been found to be associated with a number of consequences such as depression, post-traumatic stress disorder (PTSD), internalising and externalising behaviours of the child (Ackerman, Newton, McPherson, Jones, & Dykman, 1998; Alisic, Jongmans, van Wesel, & Kleber, 2011; Gilbert et al., 2009; Janson et al., 2011). Research has also revealed the negative cumulative effect of multiple traumatic experiences causing polyvictimisation/polytraumatisation in children and adolescents (Finkelhor, Ormrod, & Turner, 2007; Greeson et al., 2011; Gustafsson, Nilsson, & Svedin, 2009; Nilsson, Gustafsson, & Svedin, 2010). Studies have also shown that physical abuse is a risk factor for poor mental health in adulthood with a variety of different symptoms (Springer, Sheridan, Kuo, & Carnes, 2007).

A continuous discussion and debate about the rights and benefits of using corporal punishment is happening in different societies. The line between physical abuse and corporal punishment is unclear and is interpreted differently in various countries and differently within some countries (Janson, et al., 2011; Whipple & Richey, 1997). This could be one of the reasons why there is a shortage of research on physically abused children and the treatment of those children. Numerous treatment programmes offer parents only interventions based on strengthening the parenting capacity. These programmes do not take into consideration the bidirectional relationships between parent and child, which is an important aspect (Shaffer, Lindheim, Kolko, & Trentacosta, 2012.) There are at least two evidence-based treatment programmes for physically abused children, which involve both parent and child (NREPP, 2012). One is Parent–Child Interaction Therapy, which has shown good results in reducing future abuse reports and which has been used in a randomised field trial (Chaffin

et al., 2004; Chaffin, Funderburk, Bard, Valle, & Gurwitch, 2011). The other treatment programme, Combined Parent–Child Cognitive–Behavioral Therapy for Families at Risk of Child Physical Abuse (CPC-CBT), was proposed by Runyon, Deblinger, Ryan, and Thakkar-Rolar (2004) and has been evaluated in two different studies (Runyon, Deblinger, & Schroeder, 2009; Runyon, Deblinger, & Steer, 2010). The CPC-CBT model consists of three components: Parent Intervention, Child Intervention, and Parent–Child Intervention. Parents and children attend 16 two-hour sessions over a 16-week period. Parents and children attend separate groups conducted concurrently for the first hour and 45 minutes of the session, while the last 15 minutes involve a joint parent–child session. As the programme progresses, more time is allocated to the joint parent–child sessions. Two therapists lead the child and parent groups, respectively. The programme can serve an individual family as well as a group of families (two to four families).

The goals for the treatment (Runyon et al., 2009) are: to decrease the risk of the recurrence of physical abuse episodes; to assist parents in correcting unrealistic expectations and misinterpretations of the child's behaviour; to increase parents' ability to manage their anger and utilise non-violent child management skills; to increase positive parent–child interactions; and to improve the child's overall emotional adjustment. Therapeutic strategies used with parents include motivational interviewing, psycho-education, and development of adaptive coping skills, non-coercive parenting strategies, and problem-solving skills. Therapeutic strategies used with children include development of positive coping and anger management skills and a gradual exposure through the use of a trauma narrative. Parents and children collaborate in an abuse-clarification process, and jointly develop a family safety plan. A detailed presentation of the programme can be found in other publications (Runyon et al., 2004, 2009).

The outcome of treatment has been examined through a pilot study (Runyon et al., 2009) and through a study examining comparative efficacy for CPC-CBT compared with Parent-Only CBT (Runyon et al., 2010). The pilot study included 12 caregivers and 21 children. Both parents and children reported significant pre-treatment to post-treatment reductions in the use of physical punishment, with further improvements by way of reduced parental anger toward children, more consistent parenting and the reduction of the children's post-traumatic stress symptoms and behavioural problems. In the second study, the effects of CPC-CBT were compared with the effects of Parent-Only CBT. The study included 24 parents and 34 children in CPC-CBT and 20 parents and 26 children in Parent-Only CBT. Children and parents in the CPC-CBT group demonstrated greater improvements in total post-traumatic symptoms and positive parenting skills respectively, compared with those who participated in the Parent-Only CBT group. Parents in the Parent-Only CBT group reported using less corporal punishment to manage their children's behaviour post treatment, than parents in the CPC-CBT group.

The treatment model was introduced in Sweden in 2007, by one of the developers of the model (Runyon). This pilot study was carried out in the Swedish context in

order to examine the usefulness of the model in Sweden and whether the promising results reported by Runyon and colleagues (2010) could be confirmed.

Methods

Four units within the Child Protection Services and Child and Adolescent Psychiatry in different parts of Sweden (Kristianstad, Linköping, Lund, and Malmö) participated in the project from 2007, the year that the CPC-CBT programme was introduced. The teams were trained to work in accordance with the model by the developer of the programme. The staff that provided the treatment at the four sites were primarily trained social workers with varying levels of post-qualification training in CBT, attachment therapy and family therapy. As of 2012, more than 100 families with a history of physical abuse have completed the CPC-CBT treatment within the four units in Sweden.

Participants

Before referral to treatment, an initial assessment of the reported child abuse was made by social workers at the child protection service of the four project sites. They examined whether the reports of the child being physically abused were substantiated and whether an integrated treatment was appropriate in regard to the need for protection of the child.

Families referred to CPC-CBT treatment from June 2010 to December 2011 were invited to participate in the study. Out of 25 families, 22 agreed to participate. Four families did not complete the treatment and consequently data from those families are not included in the study. The final sample consists of 18 families, made up of 26 adults and 25 children. Ten parents participated as the only adult of their family and eight couples participated. The mean age of the adults was 39.3 (standard deviation [SD] = 6.9, range 30–50 years). The number of children in the household of the participating families varied from one to four with a mean of 2.2 (SD = 1.04). The number of children from each family that participated in the treatment varied from one to three (mean 1.4, SD = 0.70). Of the participating children, 15 (60%) were boys and 10 (40%) were girls. The children had an average age of 9.2 years (SD = 1.8), ranging from 6 to 14 years.

The majority (89%) of the adults were biological parents of the child. Other caregivers were either step-parents or adoptive parents. Throughout this paper, the female caregiver is referred to as the mother and the male caregiver as the father.

Data Collection

Adults and children responded to self-report questionnaires and were interviewed before treatment started and in connection with completion of the treatment. When two parents participated they were both asked to individually respond to the questionnaires. Therapists or researchers administered the pre-treatment data

collection. Researchers or therapists, other than the therapist of the client, administered the post-treatment data collection. Four questionnaires were used for children and five for parents during pre-treatment and post-treatment data collection.

Data were collected at the unit where the treatment was carried out. Adult participants took 60–120 minutes to complete the forms at each screening session. The post-treatment data were collected within a week of the completion of the treatment for the majority of families and at the most four weeks after completion. No financial compensation for participation was offered to participants.

Assessment Instruments Completed by Children

Children's Depression Inventory

The Children's Depression Inventory (CDI; Kovacs, 2003) consists of 27 items assessing depressive symptoms in youths aged 8–17. Total score ranging from zero to 54. The CDI has good internal validity and test–retest reliability (Finch, Saylor, & Edwards, 1985; Ivarsson, Svalander, & Litlere, 2006; Saylor, Finch, Spirito, & Bennett, 1984; Smucker, Craighead, Craighead, & Green, 1986) and has been shown to distinguish between depressed and non-depressed children (Kovacs, 1985). To determine the level of depressive symptoms reported by children, the CDI total score was utilised, with higher scores indicating more symptomatology. A cut-off score of 13 has been suggested to indicate depression. The internal consistency for this sample was good ($\alpha = 0.80$).

Trauma Symptom Checklist for Children

The Trauma Symptom Checklist for Children (TSCC; Briere, 1996) evaluates trauma-related symptoms in children and adolescents. The TSCC is a 54-item self-report instrument consisting of six clinical scales. The child is asked to indicate how often each item happens to him or her, on a four-point scale (0 = never; 1 = sometimes; 2 = lots of times; 3 = almost all the time). Studies of the TSCC have demonstrated modest inter-correlation among subscales, good internal consistency, and good concurrent and predictive validity (Lanktree & Briere, 1995; Sadowski & Friedrich, 2000). The TSCC has been translated into Swedish and the psychometrics have been investigated. The translation has been found to show a good level of reliability: Cronbach's alpha for the total scale was $\alpha = 0.94$ ($\alpha = 0.78$ – 0.83 in the clinical scales), and test–retest reliability for the total scale was $r = 0.81$ ($r = 0.67$ – 0.81 in the clinical scales). Construct validity was investigated by conducting a confirmatory factor analysis where the six supposed clinical scales were found. Criterion-related validity was tested by comparing the scores from a normative group ($n = 724$) and a clinical group ($n = 91$), and significant differences were found for all of the clinical scales ($p < 0.001$; Nilsson, Wadsby, & Svedin, 2008). In this study, scores were calculated for five subscales (anxiety, depression, anger, post-traumatic stress, dissociation) as well as the total score. The internal consistency for this sample was good ($\alpha = 0.90$).

Assessment Instruments Completed by Parents

Children and parenting strategies

The questionnaire used (Janson et al., 2011) has been modified from the Parent–Child Conflict Tactics Scale (Straus, Hamby, Finkelhor, Moore, & Runyan, 1998) and has previously been used in Swedish research on child physical abuse. The questionnaire consists of 24 items covering socio-demographic information, roles within the family, parental style, experiences of childhood physical abuse and attitudes to parenting.

Beck Depression Inventory—II

The Beck Depression Inventory—II (Beck, Steer, & Brown, 1996) is a widely-employed measure of depressive symptomatology in adults. The Beck Depression Inventory—II has been demonstrated to have good psychometric properties. The higher the total score, the more depressive symptomatology is present. A cut-off score of 14 or higher indicates mild depression, over 20–28 indicates moderate depression, and 29 and over indicates severe depression. Total scores of parental depression were used. Internal consistency for this sample was good ($\alpha = 0.92$).

Child Behavior Checklist

The Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1991) was completed by parents at both screening points. The CBCL has good psychometric properties (reliability, concurrent and treatment validity) and has been used in several treatment-outcome studies in child welfare (Kolko, 1996). The scales reflecting internalising and externalising problems were examined. Gender and age-specific *T* scores were employed when presenting the data (Achenbach & Rescorla, 2001). Internal consistency was good for the sample ($\alpha = 0.94$).

Assessment Instruments Completed by Child and Parent

K-SADS Post-traumatic Stress Disorder Interview

The K-SADS Post-traumatic Stress Disorder Interview (K-SADS PTSD; Kaufman et al., 1997) was used to assess the presence or absence of PTSD symptoms. The child and the caregiver were interviewed separately by the interviewer with their responses noted, and a summary score was derived from the information. This instrument has demonstrated good reliability (Kaufman et al., 1997). The K-SADS-PTSD interview was administered pre and post treatment, in order to assess improvements in post-traumatic stress symptoms. The number of traumatic experiences, the screening score and total symptom score were examined for this study. Internal consistency was $\alpha = 0.79$ for the parent form and $\alpha = 0.65$ for the child form.

Alabama Parenting Questionnaire—Self Report

The Alabama Parenting Questionnaire—Self Report (Frick, 1991) is a 42-item scale that was used to assess parenting practices across five domains: parental involvement,

positive parenting, poor monitoring/supervision, inconsistent discipline, and corporal punishment. Parallel forms for parents (Parent Global Report) and children (Child Global Report) were used in the study. Parents completed the Alabama Parenting Questionnaire—Self Report for each child participating in treatment. Respondents rated the frequency of engaging in/experiencing the parenting practices on a scale of one (never) to five (always). Parent-reported and child-reported positive parenting, parental inconsistency, and use of corporal punishment were examined to identify possible changes in parent–child interactions across assessments. Internal consistency for the parent form was $\alpha = 0.69$ and $\alpha = 0.79$ for the child form.

Completed forms were available for the majority of parents and children; however, between one and four forms were missing for five children and six parents. Forms were not completed due to language problems among parents or due to administrative error. The forms were read aloud for the younger children. Some young children did not fully respond to the forms but left out questions that were too difficult to understand. The number of left-out items did not exceed 10% of the total items of the form.

Some forms (Alabama Parenting Questionnaire—Self Report, K-SADS and CBCL) were completed by both parents for each participating child. As such, the number of parent-completed forms regarding children is greater than the number of parents that participated.

When examining the effects of treatment, the pre and post scores for each participant were compared and consequently those who responded at only one of the screening points were excluded from that calculation.

Ethical Approval

The study was approved by the Regional Ethical Review Board of Linköping, Sweden (Dnr 206-08).

Statistical Analysis

Possible differences for continuous variables were examined by paired *t*-test. Cohen's *d* was used to calculate effect size. The cut-off points used in the analysis were ≥ 0.80 indicating large effect, ≥ 0.50 indicating moderate effect and ≥ 0.20 indicating small effect (Cohen, 1988). The statistical software SPSS, version 20.0, was used for all calculations.

Results

The Background Factors of the Families

Sixteen parents were born outside Sweden, either in other countries in Europe or outside Europe (Table 1). Three (19%) of those reported immigrating to Sweden as children (before the age of 18).

Table 1 Socio-demographic Data of Parents

Socio-demographic variable ($n = 26$)	Male (%)	Female (%)	Total (%)
Minority ethnicity ^a	6 (60)	10 (63)	16 (62)
Employment/student ^b	8 (80)	11 (69)	19 (73)
Experience of physical abuse in childhood ^c	5 (50)	12 (75)	17 (65)

Notes: ^aDefined as born in a country outside Sweden. ^bDefined as part-time/full-time work or studies. ^cDefined as experience of occasional or frequent physical abuse in childhood.

The majority ($n = 19$, 73%) of the adults were employed, self-employed or studied. Three parents were on paternal leave or were staying at home to take care of their children. Two participants responded as being unemployed and one as being on sick leave. Parents were asked whether they had any experience of being physically abused during childhood. The majority ($n = 17$, 65%) of the parents reported that during childhood they were victims of physical abuse committed by their parents. The physical abuse was occasional or frequent and occurred in most cases when they were under the age of 13. The mother and the father were equally common perpetrators of the abuse.

The Abusive Behaviour

The physical abuse of the child was most commonly identified by the school (82%) and reported to child protection services. In the other cases, abuse was reported by relatives or health services. In three of the 18 families there was a previous record with the child protection service of violence against family members. The children in the sample were exposed to a variety of physically abusive behaviours such as being smacked or hit in the face, head or elsewhere on the body. Some of the children were beaten with objects, strangle-held or locked up in a room. Others had experiences of being pushed down the stairs, against a wall or against furniture. In most cases, a mixture of violent acts had occurred. In 10 families the mother abused the child, in six families the father abused the child and in two families both parents abused the child. A majority of parents reported that they were feeling stressed or tired when in conflict with the child. No parent reported being under the influence of alcohol when having the conflict.

Entering Treatment

Nineteen (76%) of the children were identified as the victim of abuse on entering the programme and six children were siblings of the abused child. Five children in the sample were initially removed from the home after disclosure and returned home during the treatment. Initially a majority of the parents (59%) admitted being responsible for abusing to child, but sometimes downplayed the behaviour and the potential harm to the child. When treatment was completed, parents of all but one family (94%) admitted responsibility for the physical abuse. For the majority of families (83%), the treatment programme was run individually and three families

received treatment within a group. For two immigrant families with insufficient knowledge of the Swedish language the therapists used interpreters during the whole treatment programme, and for one immigrant family the programme was run in English.

Parent Measures

Parents reported high average levels of depression pre treatment (Table 2). Two adults reported pre-treatment scores indicating mild depression, two indicated moderate depression and one reported scores indicating severe depression. There was a significant reduction of symptoms post treatment with no participant reporting scores indicating depression.

Table 2 Parent's Report on Depression and Parenting Strategies

Variable	Pre treatment, mean (SD)	Post treatment, mean (SD)	<i>t</i> value	<i>p</i> value	<i>d</i>
Depression ^a (<i>n</i> = 20)	11.0 (10.1)	2.8 (3.5)	4.31	0.000	1.21
Positive parenting ^b (<i>n</i> = 21)	23.6 (3.1)	25.0 (3.3)	1.93	n.s.	
Inconsistent parenting ^b (<i>n</i> = 21)	16.7 (3.2)	13.3 (3.0)	3.66	0.002	1.10
Corporal punishment ^b (<i>n</i> = 21)	4.4 (2.1)	3.2 (0.9)	2.29	0.033	0.80

Notes: n.s., not significant. ^aDepression measured by Beck's Depression Inventory—II. ^bParenting strategies measured by the Alabama Parenting Questionnaire.

Parents responded on parenting strategies, and three subscales were examined. Significant changes, with a large effect size, were identified for the scales of inconsistent parenting and corporal punishment (Table 2).

On the CBCL, parents reported externalising and internalising symptoms in their children pre treatment. Initially, nine parents (33%) reported children having internalising symptoms within the clinical (six) or subclinical (three) range and 19 (70%) reported externalising symptoms within the clinical (16) or subclinical (three) range. Significant changes were identified on both scales from pre treatment to post treatment (Table 3).

Parents and children reported post-traumatic stress symptoms. According to 29 parent reports, all but four children had traumatic experiences, with an average of 2.0 different experiences (*SD* = 1.5). The most common experience for children, as reported by parents, was being physically abused (reported in 18 parent reports), being exposed to domestic violence (*n* = 9) and being confronted with traumatic news (*n* = 7). For four of the children, parents reported additional traumatic experiences at the post-treatment interview, such as admitting that the child had been physically abused or exposed to domestic violence. In some families, severe accidents or illness of relatives occurred during treatment, which affected the child negatively. Significant reductions were identified when comparing the score for screening items from pre treatment to post treatment (Table 3). Also, the total symptoms of post-traumatic stress syndrome reported by parents were significantly reduced by post treatment.

Table 3 Parent's Reports on Children's Internalising, Externalising Behaviour and Trauma Symptoms

Variable	Pre treatment, mean (SD)	Post treatment, mean (SD)	<i>t</i> value	<i>p</i> value	<i>d</i>
CBCL internalising, <i>T</i> score ^a (<i>n</i> = 27)	56.2 (13.6)	48.0 (11.2)	3.32	0.003	0.66
CBCL externalising, <i>T</i> score ^b (<i>n</i> = 27)	63.1 (11.6)	54.7 (12.1)	3.74	0.001	0.71
Traumatic experiences ^c	2.0 (1.5)	2.1 (1.6)	0.90	n.s.	
PTSD, screening items ^c	3.3 (3.1)	1.3 (2.4)	4.38	0.000	0.71
PTSD, total symptoms ^d	3.1 (3.5)	0.8 (2.2)	2.38	0.032	0.79

Notes: n.s., not significant. ^aInternalising symptoms measured by the CBCL. ^bExternalising symptoms measured by the CBCL. ^cParents' response on traumatic experience on K-SADS (29 reports). ^dSymptoms of PTSD screened by five items in accordance with K-SADS. ^eTotal PTSD score (14 items) measured by K-SADS.

The Child Measures

Children responded to the CDI with a mean score of 8.5 (SD = 5.9) in a range of 0–23 at the pre-treatment measure. Five children (21%) responded with high levels of depression at pre-treatment screening. The children reported scores of 13 or more, indicating depression. There was a significant reduction of depressive symptoms from pre-treatment to post-treatment screening (Table 4). Children responded to the child version of the Alabama Parenting Questionnaire on the parenting strategies they had perceived. Three subscales were used, with six items measuring positive parenting, three items measuring corporal punishment and six items measuring inconsistent parenting. Children reported significantly improved positive parenting and a significant reduction in use of corporal punishment from pre-treatment to post-treatment screening, with large effect size. There was an agreement in child and parent reports of a significant change on the corporal punishment scale with a large effect for both children and parents. Parents reported a significant reduction in inconsistent parenting not reported by children.

Table 4 Children's Reports on Depression and Perceived Parenting

Variable	Pre treatment, mean (SD)	Post treatment, mean (SD)	<i>t</i> value	<i>p</i> value	<i>d</i>
Depression ^a (<i>n</i> = 23)	8.5 (5.9)	4.8 (5.3)	3.61	0.002	0.66
Positive parenting ^b (<i>n</i> = 20)	19.6 (5.3)	23.8 (4.4)	3.13	0.006	0.86
Inconsistent parenting ^b (<i>n</i> = 20)	14.5 (4.0)	12.9 (2.7)	1.75	n.s.	
Corporal punishment ^b (<i>n</i> = 20)	5.8 (1.8)	3.2 (0.4)	6.33	0.000	2.36

Notes: n.s., not significant. ^aDepression measured by the CDI. ^bParenting strategies measured by the Alabama Parenting Questionnaire.

Post-traumatic stress among children was screened by K-SADS pre and post treatment (Table 5). Of 21 child respondents, all but two initially reported traumatic experiences. They reported on average 2.3 traumatic experiences (SD = 1.5) ranging from zero to five different traumatic experiences. Children most frequently reported

Table 5 Children's Reports on Post-traumatic Stress Disorder and Trauma Symptoms

Variable	Pre treatment, mean (SD)	Post treatment, mean (SD)	<i>t</i> value	<i>p</i> value	<i>d</i>
Traumatic experiences ^a	2.3 (1.5)	2.4 (1.6)	1.00	n.s.	
PTSD, screening items ^b	5.3 (3.0)	1.3 (3.5)	4.00	0.005	1.21
PTSD, total scores ^c	4.5 (5.8)	1.4 (5.5)	1.80	0.093	0.54
Trauma symptoms ^d	27.9 (14.6)	13.6 (11.9)	6.34	0.000	1.06
Total scores					
Anxiety ^e	5.4 (4.1)	2.9 (2.9)	4.36	0.000	0.71
Depression ^e	4.7 (2.6)	2.1 (3.0)	3.62	0.000	0.93
Anger ^e	4.3 (3.4)	2.2 (2.3)	4.18	0.000	0.75
PTSD ^e	7.6 (4.5)	3.9 (3.3)	5.15	0.000	0.95
Dissociation ^e	6.2 (4.4)	3.2 (3.4)	3.58	0.000	0.77

Notes: n.s., not significant. ^aNumber of traumatic experiences reported on K-SADS. ^bPTSD screening scores measured by K-SADS, using five screening items for those who reported traumatic experiences. Twenty-one children completed the forms. ^cPTSD scores measured by K-SADS, total score on 14 items, for those who reported traumatic experiences. ^dTSCC including 54 items. Twenty-two children completed the forms. ^eSubscales of the TSCC including 9–10 items.

being a victim of physical abuse (80%), witnessing domestic violence (38%) and other traumatic experiences (37%). The latter was described as witnessing a violent accident or crime or the loss of a significant person. The overall symptoms were significantly reduced according to the screening items. The total score was reduced from pre to post treatment but not significantly. For one child a new trauma occurred, which increased his total score extensively.

When comparing the reported traumatic-experience scores from parents and children, some differences were identified. Parents reported slightly lower overall scores than children (4.2, SD = 3.2 vs. 4.9, SD = 3.2) for traumatic experiences. When analysing the data for siblings of an abused child participating in treatment there was also a difference, although non-significant, regarding the reported trauma experiences for this group by parents (3.5, SD = 1.9) and by children (4.5, SD = 4.1).

The children also reported trauma symptoms on the TSCC. A significant reduction of total trauma symptoms was identified from pre to post screening with a large effect size. Significant reductions were found on subscales. For the subscales depression and PTSD, the reduction reached a large effect size.

Discussion

This pilot study aimed to evaluate the significance of using a structured intervention for physically abused children. The CPC-CBT intervention engages both parents and the abused child in a 16-week programme. The results from this study can be summarised in four findings.

First, the overall results of this study are very promising and the intervention shows good effects on the targeted aspects of mental health, trauma symptoms and adverse parenting for the CPC-CBT treatment in a Swedish context.

Second, both parents and children report decreased levels of depression after treatment. Five parents reported mild to severe depression before treatment and nobody had scores indicating depression after treatment. It is known from previous research that parental depression is a risk factor for child physical abuse (Kotch, Browne, Dufort, & Winsor, 1999). Depression may be associated with a number of risk factors. Experiencing failure in parenting is one factor that could increase depression among parents. Breaking this cycle of depression and parenting failure could be vital for an intervention programme targeting child physical abuse.

Third, one of the most significant findings in relation to the child was the reduction of trauma symptoms. Traumatic experiences can have extensive short-term and long-term impacts on health, relationships and the social adjustment of children. The children in the sample reported an average of two traumatic experiences. In addition to physical abuse, the most prevalent traumatic experience was, as in several other studies, being exposed to domestic violence (Annerbäck, Wingren, Svedin, & Gustafsson, 2010; Jansson et al., 2011). The CPC-CBT probably targets those experiences as well through an approach that includes different kinds of violence. The self-reports of children at post treatment are in accordance with parents reporting a significant reduction of trauma symptoms in their children. The child intervention in the programme is influenced by Trauma Focused CBT, which has extensive support in reducing symptoms of PTSD, as well as symptoms of depression, in children who have experienced different traumas (Cohen, Mannarino, & Iyengar, 2004). The findings in this study, of a significant reduction in child trauma symptoms, confirm the previous support for this approach.

Fourth, the reduction of violent parenting is another vital goal for the treatments. The children reported a higher prevalence of physically abusive parenting pre treatment than parents did. This finding is not surprising as parents tend to downplay/deny the behaviour. It has been found in previous research that parents under-report the extent of violence that has occurred in the family when child and parent reports have been compared (Kolko, Kazdin, & Day, 1996). The pre-treatment reports of children may be more reliable. Parents report decreased use of violent parenting after treatment. Children confirm this through their reports of decreased physical violence at post treatment. When both children and parents report reduced violence with a large effect size, the findings may be seen as validated.

Non-violent parenting strategies and problem-solving skills are also a goal of the treatment. Parents report that they have become less inconsistent in their parenting post treatment. Children's reports of more positive parenting significantly support a change in parenting style. This finding indicates that parents use a style in which they give the children greater acknowledgement and positive feedback.

One can conclude that there are a number of similarities in the results of this pilot study to the US pilot study (Runyon et al., 2009), such as reduced depressive symptoms in children and parents, reduced trauma symptoms in children and altered parenting strategies after treatment. This indicates that the CPC-CBT model has a potential for effecting similar change for children and parents in different cultural contexts.

The long-term alteration of parenting style is an essential issue that has not been explored in this study. An informal method of assessing the prevalence of relapse in abusive behaviour among parents in the CPC-CBT treatment has been used. New reports of child physical abuse would have been addressed to the Child Protection Services where treatment providers are employed. It is likely that a member of the treatment team would be involved in a new case conference. No such relapse has been reported to the teams.

Methodological Considerations/Limitations

The study has several limitations. This is a limited clinical sample that may not be representative of Sweden-based families in which physical abuse has occurred.

We report good outcomes for the treatment model, but with no randomised design or control families the interpretation of the results is limited to a pre–post design. Consequently we cannot conclude that the treatment is more successful than other interventions. On the contrary, the pilot study could be seen as the first step in developing evidence-based practice since professionals working with physically abused children in Sweden have lacked focused interventions. Another limitation is the lack of a longer follow-up period. A long-term follow-up combined with register check for new child-abuse reports is necessary to ensure the long-term effects of the treatment programme. Based on the promising results, the next step will be to set up a new study with a quasi-experimental design that makes it possible to compare the outcome for families who received CPC-CBT treatment with those who received treatment “as usual”.

Finally, the transportability of treatment models, specifically the transporting of a model developed in one part of the world into another context, has been discussed. This transfer is generally not without problems. A distinguished model in one context may give less significant results in another context. That has been the case for multi-systemic therapy in Sweden, according to Swedish studies (Sundell et al., 2008) where multi-systemic therapy gave the same result as treatment as usual and not any better. Before implementing the programme at the project sites in Sweden there were some concerns raised about differences that could limit the usefulness of the programme in Sweden. The definitions of physical abuse were not the same for the United States and Sweden, with a zero tolerance in Sweden for physical punishment or abuse. Due to the toleration of corporal punishment to some degree in the United States, the clients who are “qualified” for treatment may be more burdened. Children who are punished more severely may be more traumatised than the abused children in Sweden. Those concerns were not confirmed.

The CPC-CBT programme seems to be very useful in the Swedish context. When comparing the outcome of the US (Runyon et al., 2009) and the Swedish pilot studies we can identify similar main findings. We can conclude that the model works very well in Sweden and that the programme supplies families with an opportunity to reduce violent parenting, improve the positive working model for the family and provide the tools needed to handle disagreements and conflicts.

References

- Achenbach, T. M., & Edelbrock, C. S. (1991). *Manual for the Child Behavior Checklist and Revised Child Behavior Profile*. Burlington: University of Vermont.
- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for the Achenbach system empirically based assessment: School age forms and profiles*.
- Ackerman, P. T., Newton, J. O., McPherson, W., Jones, J. G., & Dykman, R. A. (1998). Prevalence of post traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse & Neglect*, 22, 759–774.
- Alisic, E., Jongmans, M. J., van Wesel, F., & Kleber, R. J. (2011). Building child trauma theory from longitudinal studies: A meta-analysis. *Clinical Psychology Review*, 31, 736–747.
- Annerbäck, E. M., Wingren, G. G., Svedin, C. G., & Gustafsson, P. A. (2010). Prevalence and characteristics of child physical abuse in Sweden—Findings from a population-based youth survey. *Acta Paediatrica*, 99, 1229–1236.
- Appleton, J. V., & Stanley, N. (2011). Physical abuse and corporal punishment. *Child Abuse Review*, 20, 1–5.
- Ateah, C., Secco, M., & Woodgate, R. (2003). The risks and alternatives to physical punishment use with children. *Journal Of Pediatric Health Care: Official Publication Of National Association Of Pediatric Nurse Associates & Practitioners*, 17, 126–132.
- Beck, A. T., Steer, R. A., & Brown, G. (1996). *Manual for the Beck Depression Inventory* (2nd ed.). San Antonio, TX: Psychological Corporation.
- Briere, J. (1996). *Trauma Symptom Checklist for Children (TSCC) professional manual*. Odessa, FL: Psychological Assessment Resources.
- Chaffin, M., Funderburk, B., Bard, D., Valle, L., & Gurwitch, R. (2011). A combined motivation and parent–child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of Consulting and Clinical Psychology*, 79, 84–95.
- Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L., Brestan, E. V., Balachova, T., et al. (2004). Parent–Child Interaction Therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, 72, 500–510.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Laurence Erlbaum Associates.
- Cohen, J., Mannarino, A., & Iyengar, S. (2004). Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence a randomized controlled trial. *Archives of Pediatrics & Adolescent Medicine*, 165, 16–21.
- Crouch, J. L., & Behl, L. E. (2001). Relationships among parental beliefs in corporal punishment, reported stress, and physical child abuse potential. *Child Abuse and Neglect*, 8, 533–539.
- Finch, A., Saylor, C., & Edwards, G. (1985). Children's depression inventory: Sex and grade norms for normal children. *Journal of Consulting and Clinical Psychology*, 53, 424–425.
- Finkelhor, D., Ormrod, R. K., & Turner, H. A. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse & Neglect*, 31, 7–26.
- Frick, P. J. (1991). *The Alabama Parenting Questionnaire*. Unpublished rating scale, University of Alabama.
- Gilbert, R., Spatz Widom, C., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of childmaltreatment in high income countries. *The Lancet*, 373, 68–81.
- Greeson, J. P., Briggs, E. C., Kisiel, C. L., Layne, C. M., Ake III, G. S., Ko, S. J., et al. (2011). Complex trauma and mental health in children and adolescents placed in foster care: Findings from the National Child Traumatic Stress Network. *Child Welfare*, 90, 91–108.
- Gustafsson, P. E., Nilsson, D., & Svedin, C. G. (2009). Polytraumatization and psychological symptoms in children and adolescents. *European Child & Adolescent Psychiatry*, 18, 274–283.
- Ivarsson, T., Svalander, P., & Litlere, O. (2006). The children's Depression Inventory (CDI) as a measure of depression in Swedish adolescents. A normative study. *Nordic Journal of Psychiatry*, 60, 220–226.

- Janson, S., Jernbro, C., & Långberg, B. (2011). Kroppslig bestraffning och annan kränkning av barn i Sverige—En nationell kartläggning 2011. [Corporal punishment and other humiliating behavior towards children in Sweden—A national survey 2011]. *Stiftelsen Allmänna Barnhuset, Karlstad University*. Retrieved August 25, 2012, from http://www.allmannabarnhuset.se/data/files/B_cker_PDF/Kroppslig_bestraftning.pdf
- Kassam-Adams, N., & Fein, J. A. (2003). Posttraumatic stress disorder and injury. *Clinical Pediatric Emergency Medicine*, 4, 148–155.
- Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., et al. (1997). Schedule for affective disorders and schizophrenia for school-age children-present and lifetime version (K-SADS-PL): Initial reliability and validity data. *Journal of American Academy of Child & Adolescent Psychiatry*, 36, 980–988.
- Kolko, D. J. (1996). Individual cognitive-behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment*, 1, 322–342.
- Kolko, D. J., Kazdin, A. E., & Day, B. T. (1996). Children's perspective in the assessment of family violence: Psychometric characteristics and comparison to parent reports. *Child Maltreatment*, 1, 156–167.
- Kotch, J. B., Browne, D. C., Dufort, V., & Winsor, J. (1999). Predicting child maltreatment in the first 4 years of life from characteristics assessed in the neonatal period. *Child Abuse & Neglect*, 23, 305–319.
- Kovacs, M. (1985). The children's depression inventory (CDI). *Psychopharmacology Bulletin*, 21, 995–998.
- Kovacs, M. (2003). *The Children's Depression Inventory (CDI): Technical manual*. North Tonawanda, NY: Multi-Health Systems.
- Lanktree, C. B., & Briere, J. (1995). Outcome of therapy for sexually abused children: A repeated measures study. *Child Abuse & Neglect*, 19, 1145–1155.
- Nilsson, D., Gustafsson, P., & Svedin, C. G. (2010). Self-reported potentially traumatic life events and symptoms of post-traumatic stress and dissociation. *Nordic Journal of Psychiatry*, 64, 19–26.
- Nilsson, D., Wadsby, M., & Svedin, C. G. (2008). The psychometric properties of the Trauma Symptom Checklist for Children (TSCC) in a sample of Swedish children. *Child Abuse & Neglect*, 32, 627–636.
- NREPP. (2012). *The National Registry of Evidence-based Programs and Practices*. US Department of Health and Human Services. Retrieved August 25, 2012, from <http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=physical%20abuse>
- Runyon, M., Deblinger, E., Ryan, E., & Thakkar-Kolar, R. (2004). An overview of child physical abuse: Developing an integrated parent-child cognitive-behavioral treatment approach. *Trauma, Violence & Abuse*, 5, 65–85.
- Runyon, M. K., Deblinger, E., & Schroeder, C. M. (2009). Pilot evaluation of outcomes of Combined Parent-Child Cognitive-Behavioral Group Therapy for Families at Risk for Child Physical Abuse. *Cognitive And Behavioral Practice*, 16, 101–118.
- Runyon, M. K., Deblinger, E., & Steer, R. A. (2010). Group cognitive behavioral treatment for parents and children at-risk for physical abuse: An initial study. *Child & Family Behavior Therapy*, 32, 196–218.
- Sadowski, C. M., & Friedrich, W. N. (2000). Psychometric properties of the Trauma Symptom Checklist for Children (TSCC) with psychiatrically hospitalized adolescents. *Child Maltreatment*, 5, 364–372.
- Saylor, C. F., Finch, A. J., Spirito, A., & Bennett, B. (1984). The Children's Depression Inventory: A systematic evaluation of psychometric properties. *Journal of Consulting and Clinical Psychology*, 52, 955–967.
- Shaffer, A., Lindheim, O., Kolko, D. J., & Trentacosta, C. J. (2013). Bidirectional relations between parenting practices and child externalizing behavior: A cross-lagged panel analysis in the

- context of a psychosocial treatment and 3-year follow-up. *Journal of Abnormal Child Psychology*, *41*, 199–210.
- Scheeringa, M. S., Weems, C. F., Cohen, J. A., Amaya-Jackson, L., & Guthrie, D. (2011). Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: A randomized clinical trial. *Journal of Child Psychology and Psychiatry*, *52*, 853–860.
- Smucker, M. R., Craighead, W., Craighead, L. W., & Green, B. J. (1986). Normative and reliability data for the Children's Depression Inventory. *Journal of Abnormal Child Psychology*, *14*, 25–39.
- Springer, K. W., Sheridan, J., Kuo, D., & Carnes, M. (2007). Long-term physical and mental health consequences of childhood physical abuse: Results from a large population-based sample of men and women. *Child Abuse & Neglect*, *31*, 517–530.
- Straus, M. A., Hamby, S. L., Finkelhor, D., Moore, D. W., & Runyan, D. (1998). Identification of child maltreatment with the Parent-Child Conflict Tactics Scales: Development and psychometric data for a national sample of American parents. *Child Abuse & Neglect*, *22*, 249–270.
- Sundell, K., Lofholm, C., Gustle, L., Hansson, K., Olsson, T., & Kadesjo, C. (2008). The transportability of multisystemic therapy to Sweden: Short-term results from a randomized trial of conduct-disordered youths. *Journal of Family Psychology*, *22*, 550–560.
- United Nations. (1989). *Convention on the Rights of the Child*. Retrieved August 25, 2012, from <http://www.unicef.org/crc/>
- Whipple, E. E., & Richey, C. A. (1997). Crossing the line from physical discipline to child abuse: How much is too much? *Child Abuse & Neglect*, *21*, 431–444.
- Zolotor, A. J., Theodore, A. D., Chang, J., & Laskey, A. L. (2011). Corporal punishment and physical abuse: Population-based trends for three-to-11-year-old children in the United states. *Child Abuse Review*, *20*, 57–66.