Reducing the Risk for Child Physical Abuse among High-Risk Parents

A Pilot Test of a Brief Parenting Intervention Augmented with Emotion Regulation Skills Training

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Presentation Overview

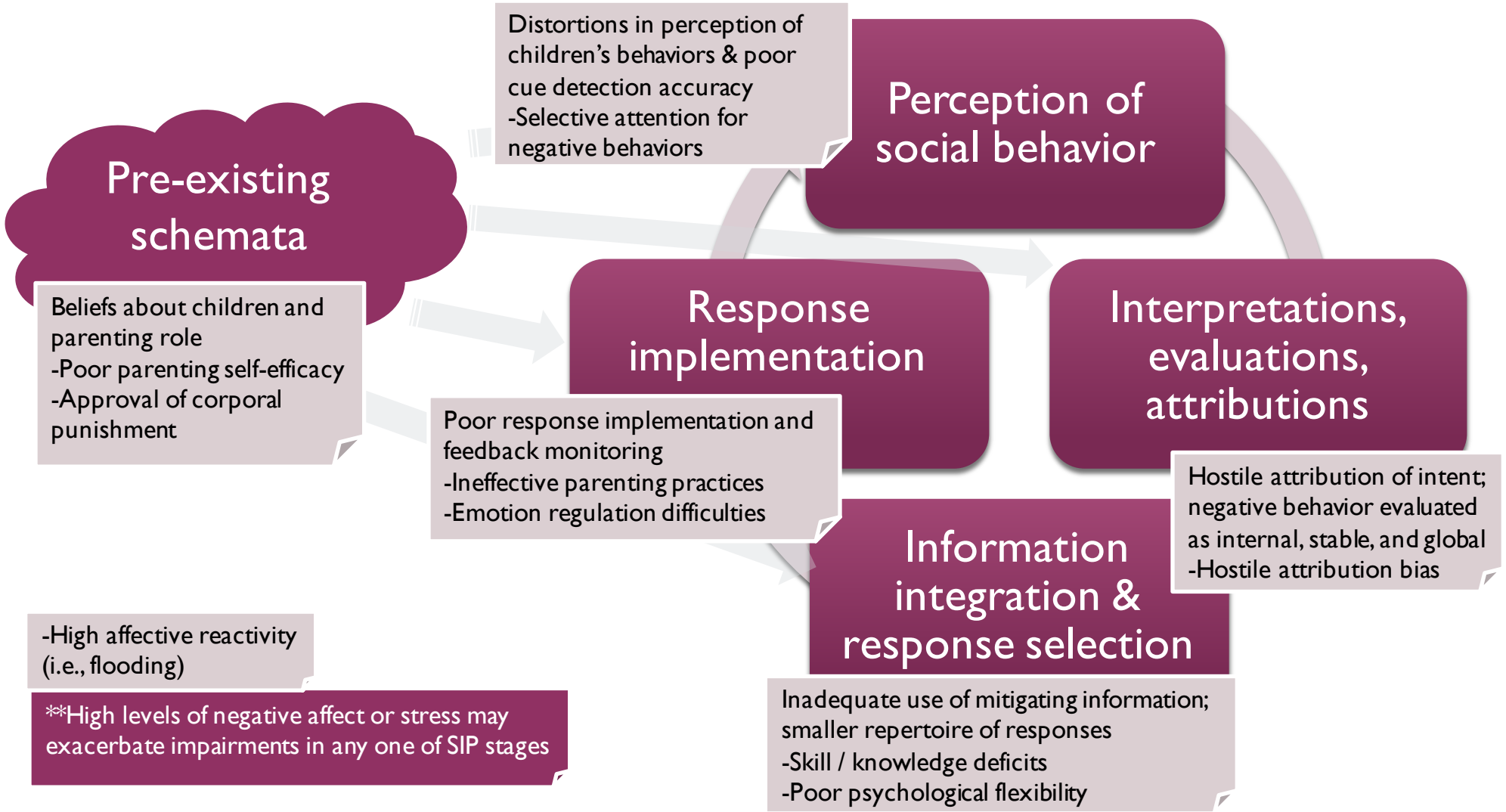
I. Introduction & Theoretical Framework
II. Pilot Study
III. Purpose & Significance of Proposed Study
IV. Research Questions & Proposed Methodology
V. Remaining Issues and Methodological Considerations

Child Physical Abuse (CPA)

- Approximately 20% of children in the United States were victims of child maltreatment in 2013, with physical abuse comprising 18% of child maltreatment incidents
  - Majority (91.4%) of child maltreatment is perpetrated by one or both parents

- Definition of CPA according to State of Illinois: intentional infliction of actual physical injury, substantial risk of physical injury, or excessive corporal punishment by a caregiver that would be likely to impair a child's physical or emotional health
  - Physical abuse ≠ physical discipline.

Parental Risk Factors within Social Information Processing (SIP) Model of CPA



Pilot Study: Testing Theoretical Underpinnings

- Examined whether emotion regulation (ER) difficulties contributed to CPA risk, even after accounting for parenting behavior and parenting sense of competence
- Screening measures:
  - Child Abuse Potential Inventory (CAPI; Milner, 1986)
  - The Parenting Scale (PS; Arnold, O'Leary, Wolff, & Acker, 1993)
  - Parenting Sense of Competence Scale (PSOC; Gibaud-Wallston & Wandersman, 1978)
  - Difficulties in Emotion Regulation Scale-Modified (DERS-M; Bardeen, Fergus, Hannan, & Orcutt, 2015; Gratz & Roemer, 2004)

Pilot Study: Participants

- 109 parents who had children under the age of 18 living in the home participated in this study.
  - Exclusionary Criteria: No child under age 18 living in the home (n = 4), random responding (n = 7), low risk but faking good (n = 28), missing > 10% of data on CAPI (n = 14)

- Final sample of 56 (LR: n = 23; HR: n = 33*)
  - Gender: 66.1% female
  - Race: 26.8% Caucasian, 67.9% African American, 5.3% other
  - Age: M = 33.74 years (SD = 10.04)
  - Marital Status: 42.9% single, 30.4% married
  - Educational Attainment: 23.2% HS diploma or GED, 42.9% some college, 28.6% Associate's / Bachelor's / graduate degree

* High risk for CPA indicated by clinically significant scores on the CAPI (Abuse Scale Score ≥ 166).

Preliminary Findings from Pilot Study (Bivariate Correlations)

	1	2	3	4	5
1. CAPI Abuse Scale	--				
2. Overreactive Parenting (PS)	.09	--			
3. Lax Parenting (PS)	.32**	.52***	--		
4. Parenting Self-Efficacy (PSOC)	-.57***	-.12	-.05	--	
5. ER Difficulties (DERS)	.48***	.26*	.08	-.52***	--
M	189.29	2.62	2.83	71.96	57.12
SD	92.02	.75	1.05	8.85	18.10

Note. $N = 54$. CAPI = Child Abuse Potential Inventory; PS = Parenting Scale; DERS = Difficulties in Emotion Regulation Scale; PSOC = Parenting Sense of Competence Scale. Reported correlations are one-tailed.
*$p \leq .05$; ** $p \leq .01$, *** $p \leq .001$

Preliminary Findings from Pilot Study: Predictors of CAPI

Table 1. *Multiple Regression Predicting Child Abuse Potential.*

Predictor	β	t	p	Adjusted R^2
Overreactive Parenting	-.24	-2.03	.048	
Lax Parenting	.44	3.81	< .001	
Parenting Self-Efficacy	-.46	-3.98	< .001	
ER Difficulties	.27	2.25	.029	.48***

N = 54. *** $p < .001$. $R^2 = .52$, Adjusted $R^2 = .48$, $F(4,49) = 13.21$, $p < .001$.
Note. All variables were centered prior to being entered in the regression analysis.

Discussion of Pilot Study Findings

- In general, results of the pilot study suggest that augmenting traditional parenting programs with an ER skills training component may be useful for high-risk parents

- Important to examine existing parenting programs and the extent to which they target ER difficulties

Extant Parenting Programs for At-Risk Parents

- Behavioral parent training programs originally developed for treatment of child externalizing problems

- Parenting programs with strongest empirical evidence base for at-risk parents:
  - Level 5 Pathways Triple-P Positive Parenting Program (Triple-P)
  - Parent-Child Interaction Therapy (PCIT)
  - The Incredible Years (IY) Advanced Program

Extant Parenting Programs for At-Risk Parents

- Existing programs for at-risk populations show promising results, but they have several limitations:
  - Extent to which programs target parental ER is variable
  - Rigorous training requirements for practitioners, large number of sessions, and limited resources often pose as barriers for community agencies seeking to implement these programs
    - Further complicated by recruitment difficulties and high attrition rates that are characteristic of at-risk populations.

Role of ER Difficulties

- ER is context-driven; no one strategy is inherently adaptive or maladaptive
  - Importance of regulatory flexibility
- ER difficulties associated with increased emotional reactivity, greater use of ineffective discipline strategies, and increased risk of engaging in child maltreatment
- High-risk and abusive parents experience greater levels of anger and frustration and are more likely to express anger through verbally or physically aggressive behavior
  - Both generally and in response to child transgressions

Pilot Study: Risk-Group Differences in ER Difficulties

- Exploratory examination of risk-group differences in endorsing items on the Strategies subscale of the DERS-M

Item (Endorsed Freq. of at least "Half of the Time")	LR	HR	Fisher's Exact Test (2-sided)
When I'm upset, I believe that I will stay that way for a long time	0%	34.4%	$p = .001$
When I'm upset, I believe that I'll end up feeling very depressed	4.3%	43.8%	$p = .002$
When I'm upset, I don't think that I can find a way to eventually feel better	0%	27.3%	$p = .007$
When I'm upset, I believe that there is nothing I can do to make myself feel better	0%	18.2%	$p = .037$
When I'm upset, I believe that wallowing in it is all I can do	4.3%	12.1%	$p = .639$
When I'm upset, it takes me a longer time to feel better	4.3%	33.3%	$p = .010$

Note. $N = 56$. DERS-M = Difficulties in Emotion Regulation Scale-Modified; LR = Low-Risk; HR = High-Risk

Purpose of Proposed Outcome Study

- Test the feasibility and acceptability of a brief (six-session) parent training program augmented with specific instruction in distress tolerance and ER skills (Enhanced Parent Management Training; E-PMT) in a sample of high-risk parents
- Assess preliminary impact of augmented program on parental risk outcomes
- Examine whether improvement in ER abilities is associated with reduction in CPA risk

Research Questions for Proposed Study

1. *Does E-PMT demonstrate feasibility and acceptability with high-risk parents?*

2. *Does E-PMT demonstrate favorable initial outcomes with respect to reducing CPA risk factors?*
   - *Parents in the E-PMT group will show greater reductions in CPA risk factors compared to parents in the WLC group.*
   - *Greater improvements in ER skills from pre- to post-treatment (i.e., change scores) will be associated with greater reductions across other CPA risk factors*

Participants & Design

- 100 parents who have children under the age of 18 living in the home and are deemed to be at high risk for CPA will be invited to participate in this study.
  - High-risk status indicated by Abuse Scale Score $\geq$ 166 on the Child Abuse Potential Inventory (Milner, 1986)

- Randomized Controlled Trial (E-PMT vs. WLC)

Measures

- Parents will complete study measures five times over the course of the study (in addition to weekly session evaluation forms)
  - Parenting Sense of Competence Scale (PSOC; Gibaud-Wallston & Wandersman, 1978)
  - Parental Acceptance Questionnaire (6-PAQ; Greene, Field, Fargo, & Twohig, 2015)
  - Parent Cognition Scale (PCS; Snarr, Slep, & Grande, 2009)
  - Difficulties in Emotion Regulation Scale-Modified (DERS-M; Bardeen, Fergus, Hannan, & Orcutt, 2015; Gratz & Roemer, 2004)
  - Parent Flooding Scale (PFS; Del Vecchio, Lorber, Slep, Malik, Heyman, & Foran, 2016)
  - Parental Emotion Regulation Inventory-Revised (PERI2; Lorber, Del Vecchio, Feder, & Slep, 2016)
  - The Parenting Scale (PS; Arnold, O'Leary, Wolff, & Acker, 1993)
  - Child Abuse Potential Inventory (CAPI; Milner, 1986)

Procedure

- Parents will attend 6 two-hour group sessions
  - Each session will include didactic and experiential components for both parent management training and emotion regulation skills training
  - Two 15-minute phone check-ins will be offered following the 3rd and 6th sessions

General Session Structure

15 minutes	Check in; review content from previous session; discuss homework
20 minutes	Didactic ER component
25 minutes	Experiential ER component & group discussion
10 minutes	Break
20 minutes	Didactic PMT component
25 minutes	Experiential PMT component & group discussion
5 minutes	Check-out; homework assignment; parent satisfaction questionnaire

Overview of Treatment

Session 1	ER: Identifying Emotions, Recognizing Triggers, Reducing Emotional Vulnerability PMT: Understanding Child Misbehavior, Behavior Analysis, Psychoeducation about Corporal Punishment
Session 2	ER: Distress Intolerant Beliefs, Challenging Distorted Thoughts PMT: Positive Attending Skills, Increasing Compliance, Effective Commands
Session 3	ER: Mindfulness I (Wise Mind), Tolerating Emotional Distress (Self-Soothing) PMT: Point System 1; Planned Ignoring
Phone Check-In	15-Minutes (ER and Point System Troubleshooting)
Session 4	ER: Mindfulness II, Radical Acceptance, Opposite Action PMT: Time Out & Other Non-Physical Disciplinary Methods Part1
Session 5	ER: Walking the Middle Path (Dialectics), Planning for Triggering Situations PMT: Time Out & Other Non-Physical Disciplinary Methods Part 2
Session 6	Problem Solving, Anticipating Problems, Skill Review
Phone Check-In	15-Minutes (General Troubleshooting & Questions)

Preliminary Assessment of Feasibility (Pilot Data)

Risk Status X Group Interest				
Interest In Group	Random Responding	Faking Good Low Risk	Valid Low Risk	**High Risk**
No	16.7% (*n* = 1)	14.3% (*n* = 4)	4.3% (*n* = 1)	15.6% (*n* = 5)
Yes	83.3% (*n* = 5)	85.7% (*n* = 24)	95.7% (*n* = 22)	**84.4% (*n* = 27)**

Remaining Issues and Methodological Considerations

- Balancing methodological rigor with clinical utility (statistically vs. clinically meaningful findings)
  1. What should the control group be?
     - WLC / treatment as usual(?) / attention placebo / other?
  2. Delivery format
     - Individual sessions are more effective but more time consuming
     - Group sessions more efficient but more difficult to schedule

- Keeping in mind that the primary question of interest is whether an ER skills training augmentation would be beneficial for this population…
  3. What is the ideal research design to address this question, and what would be a reasonable alternative that could serve as the next step?

Thoughts / Questions?

Thank you for listening!