NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

AF-CBT: Alternatives for Families– A Cognitive Behavioral Therapy

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** AF-CBT **Average length/number of sessions:** 20 (1 – 1.5 hours/each) **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)*: Logistical barriers to attendance **Trauma type** *(primary)*: Physical abuse and exposure to harsh/excessive physical punishment (use of coercion/physical force) **Trauma type** *(secondary)*: PTSD or trauma symptoms secondary to child physical abuse or physical discipline **Additional descriptors** *(not included above)*: Concurrent emotional maltreatment (verbal aggression)
Target Population	**Age range:** 5 to 17 **Gender: ❒ Males ❒ Females ☒ Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)*: Treatment is not specifically designed for any one ethnic/racial group, but has been used extensively with urban African-American families and reviewed with several African-American stakeholders in a systematic series of studies that evaluated the relevance and utility of its content/process. **Other cultural characteristics** *(e.g., SES, religion)*: Primarily, but not exclusively, modest to low-income families **Language***(s)*: Thus far, AF-CBT has been delivered in English, Spanish, Japanese, and Creole. **Region** *(e.g., rural, urban)*: Rural and urban populations **Other characteristics** *(not included above)*: AF-CBT has been primarily used in outpatient and in-home settings; however, it can be delivered on an individual basis in alternative residential settings, especially if there is some ongoing contact between caregiver and child. AF-CBT is appropriate for use with physically coercive/abusive parents and their school-age children. Related methods are designed for use with physically abused children who present with externalizing behavior problems, notably aggressive behavior, coping skills/adjustment problems, poor social competence, internalizing symptoms, and developmental deficits in relationship skills. In addition, the approach includes methods to address parent-child conflicts.
Essential Components	**Theoretical basis:** Learning/behavioral theory, family-systems, cognitive therapy, and developmental victimology, and psychology of aggression

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Essential Components continued

Key components:

Child-directed components

- Engagement and goal-setting
- Psychoeducation about force/abuse
- Disclosure of incidents involving hostility and physical force/abuse (causes, characteristics and consequences) to help child understand the context in which they occurred
- Cognitive processing of automatic thoughts that could maintain aggressive behavior or family conflict
- Training in affect identification, expression, and management skills (e.g., relaxation training, anger control)
- Social/interpersonal skills training to enhance social competence and development of social support plans
- Imaginal exposure and making meaning from the disclosure of traumatic events related to physical abuse/discipline, as needed

Caregiver/Parent-directed components

- Engagement/rapport-building that includes discussion of family of origin issues and current family circumstances
- Psychoeducation on the impact of family abuse/conflict
- Discussion of current referral reasons/child's disclosure, and family contributors to coercive behaviors
- Cognitive processing of caregiver's automatic thoughts that may promote coercive interactionsTraining in affect-regulation skills to manage reactions to abuse-specific triggers (e.g., escalating anger, anxiety, or depression)
- Training in behavior management principles and practices/strategies (e.g., reinforcement and punishment) that serve as alternatives to using physical discipline

Parent-Child or Family-System directed components

- Treatment orientation and engagement
- Clarification sessions to establish responsibility for the abuse, focus treatment on the needs of the victims/family, and develop safety and relapse prevention plans, as needed
- Communication skills training to encourage constructive and supportive interactions
- Prosocial (nonaggressive) problem-solving skills training to minimize coercion, with home practice applications to help family incorporate them in everyday routines
- Graduation and review of skills learned/safety plans

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Clinical & Anecdotal Evidence

Are you aware of any suggestion/evidence that this treatment may be harmful?
❒ Yes ☒ No ❒ Uncertain

Extent to which cultural issues have been described in writings about this intervention *(scale of 1-5 where 1=not at all to 5=all the time)*. 2

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ Yes ☒ No

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)*? **☒ Yes ❒ No**

If YES, please include citation: see articles below

Has this intervention been presented at scientific meetings? ☒ Yes ❒ No

If YES, please include citation*(s)* **from last five presentations:**

Kolko, D. J., Baumann, B. L., Shaver, M. & Higa, J. (November, 2011). Case consultation with community practitioners in an effectiveness trial: Description and evaluation. In R. Beidas (Chair). Consultation, a critical component of dissemination and implementation of empirically supported treatments. Paper presented at the 45th Annual Convention of the Association for Behavioral and Cognitive Therapies, Toronto, Ontario, Canada (11/13)

Kolko, D. J. (2011, August). AF-CBT for DBD: A Modular Approach. In John Lochman (chair), Innovations for Interventions for Disruptive Behavior Disorders. Invited paper presented at the 119th annual meeting of the American Psychology Association, Washington, D.C. (8/4). Taped for CEU credit.

Kolko, D. J. (November, 2011). NCTSN Learning Collaborative to Train Community Practitioners in AF-CBT. In R. Chase (Chair). Moving out of the ivory tower: The learning collaborative approach to the implementation of best practices in community settings. Paper presented at the 45th Annual Convention of the Association for Behavioral and Cognitive Therapies, Toronto, Ontario, Canada (11/12)

Kolko, D. J. (November, 2011). AF-CBT consultation in child welfare and mental health. In S. Decker (Chair). Consultation to improve implementation: How is it being used and what is working? Paper presented at the 45th Annual Convention of the Association for Behavioral and Cognitive Therapies, Toronto, Ontario, Canada (11/12)

Are there any general writings which describe the components of the intervention or how to administer it? ☒ Yes ❒ No

If YES, please include citation: AF-CBT Implementation Guide, v.2.2; Kolko, 1996a; Kolko, 1996b; Kolko, 2002; Kolko & Swenson, 2002

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Clinical & Anecdotal Evidence continued	**Has the intervention been replicated anywhere?** ❒ **Yes** ☒ **No** AF-CBT has been applied in several other clinical and academic settings. Reports from trained practitioners generally indicate positive results in terms of clinical improvements (e.g., reductions in parental use of force/abusive behavior, improved parent-child relationships), and successful case closures within the CPS system. **Other countries?** *(please list)* Canada, Germany, Holland, Israel, Japan **Other clinical and/or anecdotal evidence** *(not included above)*: Descriptions of the materials included in the book and the more recent session guide provide examples of their general application on an outpatient basis in addition to specific suggestions for cases that may require adaptations or special circumstances. Overall, the outcomes of these and related interventions have been fairly robust across different child and caregiver demographic background variables (e.g., age, gender, ethnicity, intellectual functioning and family constellation.) However, specific applications to specific cultural groups or settings have not been formally reported.	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**52 Child physical abuse with other forms of abuse/ trauma (e.g., 60% were sexually abused) **By gender:** 52% male; 48% female **By ethnicity:** 89% Caucasian; 3% Asian; 2% African-American; 2% Native American; 4% multi-racial	SAMHSA pilot study conducted with Safe and Healthy Families Program, Intermountain Care, Salt Lake City, UT (Kolko et al., 2011)
Randomized Controlled Trials	**N=**55 children **By gender:** 72% male **By ethnicity:** 53% African-American or biracial	NCCAN Grant, 1990-1996; Kolko, 1996a; Kolko, 1996b

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Studies Describing Modifications	Practictioners **N=**182 76% female 76% Caucasian **N=**205 55% male 56% Caucasian	Partnerships for Families; Large-scale treatment effectiveness trial – NIMH; 2006-2011; (Kolko et al., 2012)
Other Research Evidence	Children **N=**11 Ages 6-12; 73% boys; **By ethnicity:** 82% Latino and 18% African American/Black.	PARNTERS Program (St. John's University). Pilot/feasibility trial. (Brown, 2005, unpublished).

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

Agencies and individuals can choose from the assessments listed below based on target population, outcome targets, and availability of measures.

Caregiver parenting practices and distress/abuse potential

- Conflict Tactics Scales—Parent to Child version (CTSPC; Straus et al., 1998)
- Alabama Parenting Questionnaire (APQ; Shelton et al., 1996)
- Parent Perception Inventory (PPI; Hazzard et al., 1983)
- Brief Child Abuse Potential Inventory (B-CAP; Ondersma et al., 2008)

Children's behavioral and emotional problems

- Strengths and Difficulties Questionnaire (Bourdon, Goodman, Rae, Simpson & Koretz, 2005)
- Trauma Symptom Checklist for Children (TSCC; Briere, 1996)
- Child Posttraumatic Stress Scale (CPSS) or UCLA PTSD Reaction Index (Pynoos and Steinberg, 2002)

Family functioning, especially levels of conflict and cohesion

- Family Environment Scale (FES; Moos et al., 1974)

If research studies have been conducted, what were the outcomes?

Outcome evaluation can include the use of any of the above listed measures for follow-up assessment across a variety of domains (caregiver practices, child emotional and behavioral problems, family cohesion/conflict, etc.). Other measures may be found in Kolko, 2002.

Outcomes continued

Some of the methods incorporated in AF-CBT have been found efficacious in outcome studies conducted with various populations of parents, children, and families over the past three decades (see Chalk & King, 1998; Kolko, 2002). The individual and family approaches in AF-CBT were evaluated relative to routine community services (RCS) in a clinical trial that evaluated key outcomes through a one-year follow-up assessment. In an initial analysis comparing the treatment course of the two randomized conditions (individual CBT vs. family therapy; see Kolko, 1996a), weekly ratings of parents' use of physical discipline/force and anger problems were found to decrease significantly faster among the individual child and parent CBT cases than those receiving family treatment, but both showed significant improvements over time.

In terms of overall clinical outcomes through follow-up (Kolko, 1996b), both the individual CBT and family therapy conditions reported significantly greater improvements than RCS on certain child (i.e., less child-to-parent aggression, child externalizing behavior), parent (i.e., child abuse potential, individual treatment targets reflecting abusive behavior, psychological distress, drug use), and family outcomes (i.e., less conflict, more cohesion.) The official recidivism rates for CBT and family were lower (5-6%) than the rate for RCS (30%). Both CBT and family therapy had high consumer satisfaction ratings.

A CBT for child physical abuse that includes many of the components currently incorporated in AF-CBT was piloted with physically-abused children and their caregivers in a clinical program (PARTNERS) by Brown (2005). The targets for intervention were: (1) children's internalizing symptoms (including posttraumatic stress disorder) and externalizing behavior problems, (2) caregivers' recidivism, (3) children's cognitive processing of the abuse, and (4) parenting practices. In an open trial with pre-treatment, mid-treatment, post-treatment, and 3-month follow-up assessments, we examined whether mental health problems in children exposed to physical abuse can be reduced through a 16-week parent- and child-focused cognitive behavioral intervention. Eleven children (ages 6-12; 73% boys; 82% Latino and 18% African American/Black) and their primary caregivers participated. Children completed self-report measures of psychopathology, anger, and attributions about the abuse (e.g., shame, self-blame). Caregivers completed measures of parenting practice (including corporal punishment), child abuse potential, and psychopathology. At baseline, all of the children met criteria for a psychiatric disorder (APA, 1994), with 45% meeting criteria for two and 18% meeting criteria for three. The most common diagnoses were: posttraumatic stress disorder, separation anxiety disorder, and generalized anxiety disorder. Within-subjects repeated measures analyses indicated significant pre to post decreases in children's Conduct Problems and Anxiety (on the Behavioral Assessment System for Children), and Shame. Both children and their caregivers reported significant decreases in caregivers' use of corporal punishment and physical abuse.

We also conducted a study (Kolko, Iselin, & Gully, 2011) that describes the long-term sustainability and outcome of AF-CBT as delivered by practitioners in a community-based child protection program who had received training in the model several years earlier. Formerly described as Abuse-Focused CBT, AF-CBT is an evidence-based treatment (EBT) for child physical abuse and family aggression/conflict that was included in the National Child Traumatic Stress Network's initial EBT dissemination efforts in 2002.

Outcomes continued	Seven practitioners received a day-long training workshop, 12 monthly case consultation calls, and a follow-up booster workshop. The program's routine evaluation system was used to document the clinical and treatment outcomes of 52 families presenting with a physically abused child who received AF-CBT content between two and five years after training had ended. Measures of the use of AF-CBT and four other EBTs documented their frequency, internal consistency, intercorrelations, and relationship to several therapist- and parent-rated outcomes. The amount of AF-CBT General and Abuse-specific content delivered was found to predict several clinical and functional improvements in both children and caregivers, above and beyond the influence of the unique content of the other four EBTs. Specifically, the amount of AF-CBT abuse-specific content delivered was related to improvements on standardized parent rating scales (i.e., child externalizing behavior, anger, anxiety, social competence) and both parent and clinician ratings of the child's adjustment at discharge (i.e., child more safe, less scared/sad, more appropriate with peers). The amount of AF-CBT general content was related to a few discharge ratings (better child prognosis, helpfulness to parents). These novel naturalistic data document the sustainability and clinical benefits of AF-CBT in an existing community clinic serving physically abused children and their families, and are discussed in the context of key developments in the treatment model and dissemination literature. We recently published a randomized clinical trial designed to evaluate the dissemination of AF-CBT with practitioners from the child welfare and mental health systems (Kolko et al., 2012). In sample of 182 practitioners randomized to AF-CBT training or training as usual (TAU), Training and consultation in AF-CBT were provided over a 6 month period. HLM analyses revealed significant initial improvements for those in the AF-CBT training condition in knowledge about AF-CBT and its targeted population, and the use of AF-CBT teaching processes, abuse-specific skills, and general psychological skills. The training program was associated with high rates of consumer satisfaction. These supportive findings are discussed in the context of treatment training, research, and work force issues that are now being considered more fully as we develop our training program outline/structure, such as the need to understand the diverse professional experiences, client populations, and service settings of interested community practitioners.
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Clinicians are encouraged to review the Session Guide and maintain copies of relevant materials for efficient use during sessions. It is also helpful to develop and submit tapes for later review during supervision. **Supervision requirements** *(e.g., review of taped sessions)***?** We encourage routine supervision during training and a review of case progress, issues, and obstacles during routine consultation. **To ensure successful implementation, support should be obtained from:** Dr. Kolko, Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine

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Training Materials & Requirements

List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.

A recently revised training manual (session guide that includes topical content and worksheets/handouts) is provided as part of an approved training program in AF-CBT.

Kolko, DJ, Brown, EJ, Shaver, ME, Herschell, AD, & Baumann, BL. Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) Session Guide (3rd edition; November 1, 2011). Pittsburgh, PA: University of Pittsburgh School of Medicine.

How/where is training obtained?

Interested professionals can request a training through on online form posted on the AF-CBT website (URL listed below). Training is intended for masters-level mental health professionals with at least some advanced training in psychotherapy skills/methods and experience working with conflictual caregivers and their children. Participants are encouraged to review a brief summary of the treatment approach and the AF-CBT session guide (topical content and handouts/worksheets) beforehand. We offer training in the context of a year-long learning community which includes a 3-day intensive skills training workshop (didactics and experiential exercises), followed by monthly case consultation calls (often with 2 presenter/call), a booster training/seminar, reviews of treatment session audio files, and supervisor support calls to facilitate program implementation of AF-CBT. The duration of consultation may vary by level of experience and case difficulty (typical range: six to 18 hours over six to twelve months).

What is the cost of training?

The cost for a one-year, learning community in AF-CBT (often configured for up to 15 people per trainer) may vary, as it is based on an individualized training program plan and depends upon the total number of trainees, booster session modality (on site vs. videoconference), inclusion of reviews of session audio files, and travel requirements. Please contact Dr. Kolko to discuss a training program and its cost.

Are intervention materials *(handouts)* **available in other languages?**

☒ **Yes** ❒ **No** Spanish and Japanese handouts for families are available; however, the Session Guide is only available in English.

Pros & Cons/ Qualitative Impressions

What are the pros of this intervention over others for this specific group *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?**

Comprehensive content for children, parents, and families; focus on family conflict, aggression, and if applicable alternatives to the use of excessive physical discipline including child physical abuse; structured session guide with handouts to facilitate implementation.

What are the cons of this intervention over others for this specific group *(e.g., length of treatment, difficult to get reimbursement)***?**

Clinicians tailor the material to the needs of the clients, so it requires clinician decision-making about what content should be emphasized. In addition, the treatment can at times be lengthy, may involve working with difficult to engage families, and requires that practitioners draw upon considerable personal and professional resources.

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Pros & Cons/ Qualitative Impressions continued	**Other qualitative impressions:** Based on independent supervisor ratings from the author's original clinical trial (Kolko, 1996a), high levels of therapeutic integrity have been found among trained master's-level clinicians who have conducted individual CBT (81 percent) and family treatment (85 percent). A simplified version of this integrity checklist for community application is being developed.
Contact Information	**Name:** David J. Kolko, PhD, ABPP **Address:** University of Pittsburgh, School of Medicine **Phone number:** (412) 246-5888 **Email:** kolkodj@upmc.edu **Website:** www.afcbt.org
References	Brown, E. J. (2005, June). *Efficacy of a parent-child intervention for physically abused children and their caregivers*. Paper presented at the Annual Colloquium of the American Professional Society on the Abuse of Children, New Orleans, LA. 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. (1996). Clinical monitoring of treatment course in child physical abuse: Psychometric characteristics and treatment comparisons. *Child Abuse & Neglect, 20*, 23-43. Kolko, D. J. (2002). Child physical abuse. In J.E.B. Myers, L. Berliner, J. Briere, C.T. Hendrix, C. Jenny & T. Reid (Eds.), *APSAC handbook of child maltreatment* (2nd Ed., pp. 21-54). Thousand Oaks, CA: Sage Publications. Kolko, D. J. & Swenson, C. C. (2002). *Assessing and treating physically abused children and their families: A cognitive behavioral approach.* Thousand Oaks, CA: Sage Publications. Herschell, A. D., Kolko, D. J., Baumann, B.L., & Davis, A.C. (2010). The Role of Therapist Training in the Implementation of Psychosocial Treatments: A Review and Critique with Recommendations. Clinical *Psychology Review, 30*, 448-466. Kolko, D. J., Iselin, A. M., Gully, K. (2011). Evaluation of the Sustainability and Clinical Outcome of Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT) in a Child Protection Center. *Child Abuse & Neglect, 35*, 105-116. Kolko, DJ, Brown, EJ, Shaver, ME, Herschell, AD, Baumann, BL. *Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) Session Guide, third edition.* November 1, 2011. Pittsburgh: University of Pittsburgh School of Medicine. Kolko DJ, Baumann BL, Herschell, AD, Hart, JA, Holden, EA, Wisniewski, SR. (2012). Implementation of AF-CBT by community practitioners serving child welfare and mental health: A randomized trial. *Child Maltreatment, 17*, 32-46. Herschell, A. D., Kolko, D. J., Baumann, B. L.., & Brown, E. J. (in press). *Alternatives for Families: A Cognitive-Behavioral Therapy: Applications in the Schools*. Psychology in the Schools.