

## Program Overview: Alternative for Families-Cognitive Behavioral Therapy

Please note that the accuracy of the contents of this inventory cannot be guaranteed until the program director has reviewed this summary for accuracy. Changes may be pending.

Category	Cognitive Behavioral Therapy	Definitions/ Notes
<b>Program Name</b>	Alternative for Families-Cognitive Behavioral Therapy (AF-CBT)	Formerly known as Abuse-Focused Cognitive Behavioral Therapy
<b>History of Program</b>	AF-CBT was designed to address the multidimensional risks (parenting practices, child aggression, family conflict) and consequences of physical abuse, including parent, child, and family adjustment.	blank
<b>Description of Program as it Relates to addressing CEV</b>	AF-CBT is a goal-driven intervention that allows treatment to be tailored to individual family needs within a three phase structure. Each phase is comprised of several sessions that incorporate social learning, behavioral, family systems, cognitive, and developmental principals. Sessions are added, removed or repeated as needed until the family meets the goals of each phase. <i>Engagement &amp; Psychoeducation</i> focuses on assessing family's needs, increasing participant motivation and understanding of the abusive, learning about the CBT model, and agreeing to refrain from using physical force. <i>Individual Skill-Building</i> teaches parents alternatives to using hostile, coercive, and physical punishment, teaches parents and children emotional regulation skills (e.g., anger and anxiety management), and addresses children's and parent's misattributions related to the abuse (e.g., self-blame, beliefs in the effectiveness of physical punishment) . Finally, in the <i>Family Application</i> phase, time is spent on enhancing peer and social supports, enhancing family communication and building routines, and practicing behavior management, discipline, and problem-solving with clinician scaffolding.	blank

Highlighted text indicates program components are currently under review. Changes may be pending.

Category	Cognitive Behavioral Therapy	Definitions/ Notes
<b>Service Continuum</b>	Tertiary/Targeted Intervention	
<b>Primary Exposure Type</b>	Maltreatment (non-specific) Physical Abuse	
<b>Target Population</b>	Family Systems Individual Children/ Youth Parent/Caregivers(s)	
<b>Target Age</b>	Early Childhood (3-5) Middle Childhood (6 - 12) Adolescence (13-21)	4-16
<b>Target Gender</b>	Both	
<b>Appropriate for Unique Ethnic, Cultural, or Linguistic Populations?</b>	Has this program been used or evaluated with minority, cultural, or linguistically diverse groups? Yes If yes, please indicate: Latino/Hispanic African American Caucasian	
<b>What Adaptations have been made?</b>	AF-CBT is currently being translated into Spanish and adapted for Spanish-speaking cultures. It is also being adapted for families in which there is domestic violence.	
<b>Primary Settings</b>	Homes (biological/adoptive) Hospital/Pediatric Mental Health Community Agency	
<b>Persons or Entities in charge of delivering Program</b>	Mental Health Providers (e.g., Social Workers, Therapists)	
<b>Primary</b>	Assessment/ Triage/Screening	

Category	Cognitive Behavioral Therapy	<i>Definitions/ Notes</i>
<b>Components</b>	Child Individual Therapy Parent Training/Therapy Conjoint parent-child treatment	

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## Resource & Capacity Planning

Program Name	Cognitive Behavioral Therapy	Brief Description
<b>Length/Duration of Program</b>	Please Describe: AF-CBT is delivered over a 16-week (or 3-6 month) period. Clinicians meet with parents and children for 1 to 2, 60-minute sessions/week (or 18 hours of home- and clinic-based services). The minimal duration and length of contact is 12, 60-minute clinic-based sessions.	AF-CBT should be delivered in the three phase sequence, but the time spent on each phase, as well as the sessions within each phase depend on the needs of each family. The clinician is responsible to ensure that the goals of each phase are met before moving on, but may repeat or skip sessions within each phase as deemed necessary for the family to meet each goal.
<b>Required Materials</b>	Manuals/Program materials Video/Audio Equipment Fidelity Checklists/Assessments Technical Assistance	Available training and implementation materials include: <ul style="list-style-type: none"> <li>• Informational brochures</li> <li>• Implementation guide</li> <li>• Source book: Kolko, D. J., &amp; Swenson, C. C. (2002). <i>Assessing and treating physically abused children and their families: A cognitive-behavioral approach</i>. Thousand Oaks, CA: Sage publications.</li> <li>• Practice demonstration DVD</li> <li>• Treatment Session outline and guide</li> <li>• Workbook with handouts for families</li> </ul>
<b>Are Materials Available in Multiple Languages?</b>	A Spanish translation of AF-CBT materials is currently being pilot-tested.	
<b>Training Requirements</b>	Face-to-face training Supervision Consultation Other	Typical Training Sequence Includes: <ol style="list-style-type: none"> <li>1. Completing agency/ clinician readiness assessment</li> <li>2. Reading source book, session guide, &amp; workbook</li> <li>3. Attending 2 day training</li> </ol>

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		<p>workshop for each of the AF-CBT phases</p> <ol style="list-style-type: none"> <li>4. Conducting AF-CBT with 2 pilot cases and receiving on-going, bi-weekly consultations via conference calls</li> <li>5. Participating in on-going monitoring of treatment fidelity through submitted tape reviews conducted by consultants</li> </ol>
<b>Provider Certification/Training/Requirements</b>	<p>Program Specific Certification/Training Required</p> <p>Special Service Area Required (e.g., Social Worker, Doctor)</p>	<p>In addition to receiving the required AF-CBT training, providers should have Master's degree or equivalent in psychology/counseling or relevant field (some exceptions may apply), have received training in CBT practices, and have knowledge and experience with child physical abuse.</p>
<b>System or Agency Recommendations for Serving CEV Populations</b>	<p>With-in Agency Support &amp; Infrastructure: AF-CBT requires staff planning to allow pairs of clinicians to deliver simultaneous, individual treatment to child and parent and conduct the home visits. Audio/video equipment is also required for on-going monitoring.</p> <p>Prior to training, interested agencies/clinicians complete an agency readiness assessment. Findings should be discussed with relevant team members to ensure relevance of program for agency and agency's ability to support staff attendance at workshops and time allocated for bi-weekly consultations and on-going monitoring. Site-base supervision is also recommended.</p>	<p>blan</p>
<b>Costs of Implementation</b>	Not Yet Available	

## Evidence for CEV

Program Name	Cognitive Behavioral Therapy	Notes
<b>Evidence for Preventing or Addressing Violence Exposure</b>	Program demonstrates effectiveness in reducing either the risk of exposure and/or ameliorating the effects of exposure to violence (e.g., related behavioral distress, PTSD, perpetration/assault, nightmares) among children or caregivers.	
<b>Evaluation Design of Studies with CEV</b>	Randomized, control experimental design  Feasibility testing	
<b>Violence Exposure-Related Outcomes</b>	<p><b>Child (Briefly Describe)</b> Participating children show lower levels of child-to-parent violence, as well as significant reductions in abuse-related fear, feelings of being different from peers, and depression/anxiety. Improvements are also seen in children's ability to trust others over the course of treatment. Compared to children receiving other treatments (family therapy and routine community services), children in AF-CBT reported fewer problems with enemies at school and exhibited lower externalizing difficulties, with improvements remaining at 3-month and 1-year follow-ups.</p> <p><b>Parent (Briefly Describe)</b> Parents of children with psychiatric diagnosis or chronic behavioral problems show variations in response to treatment, including higher levels of at-risk behaviors during the early and late phases of treatment. However, parents and children report significant decreases in parents' overall levels of anger, and parents indicate less use of physical discipline, as well as significant reductions in the severity of physical discipline. In one study, parents in AF-CBT showed greater overall improvements than those in either family therapy or routine community services. Participating parents show a greater average</p>	

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	<p>length of time until their first use of physical force compared to those receiving family therapy. Parents also show improvements in their own psychological functioning, including feeling less distressed and depressed from intake to 3-month and 1-year follow-ups. Parents also report a significant diminishment in their beliefs about the need to use punishment, and greater improvements in self-reported parenting practices than the control condition. Initial evidence for diminishing the likelihood of re-abusing has also been found during a 1-year follow-up.</p> <p><b>Family (Briefly Describe)</b> Children whose families received AF-CBT reported significant reductions in family problems over the course of treatment. Families receiving CBT show greater family cohesion than those receiving FT or RCS and report less family conflict.</p>	
<p><b>Additional Research Information</b></p> <p>(This will be a link to another page, a drill down box or separate section)</p>	<p>Study 1: <b>Design, Setting, Participants:</b> 38 physically abused children (ages 6-13) and their parents were randomly assigned to Individual and Parent CBT or Family Therapy. An additional 11 maltreated children and their guardians receiving services in the community served as a comparison group. Physical abuse had been reported within the last 6 months (a reported 11% also had histories of sexual abuse). Participants were referred by CPS, social workers, or were self-referred. 92% of the children were abused by a caregiver currently living in their home. 50% of the children were Caucasian, 42% African American, and 8% biracial. Most children also had significant social and emotional health concerns (only 24% did not meet diagnostic criteria for a mental health disorder).</p> <p><b>Outcome Measures:</b> Child psychiatric symptoms were obtained via semi-structured interviews with parents and children using the KIDDIE-SADS-P. Indicators of child's risk for maltreatment were obtained via child and parent reports using a</p>	

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	<p>measure developed in other research, the Weekly Report of Abuse Indicators (WRAI). Continuous monitoring of parents' use of harsh physical discipline, levels of anger, and severity of family problems, as well as the number of days elapsed from prior use of physical force were obtained from parents and children at the start of each session. 3 scores were obtained from reports of physical discipline/force: presence of force and resulting injury, average amount of force/injury, and the number of days elapsed prior to first use of physical discipline.</p> <p><b>Reference:</b> Kolko, D. J. (1995). Clinical monitoring of treatment course in child physical abuse: Psychometric characteristics and treatment comparisons. <i>Child Abuse &amp; Neglect</i>(20), 23-43.</p> <p>Study 2: <b>Design, Setting, Participants:</b> 47 physically abused/maltreated children ages 6-13 (34 boys; 13 girls; 47% Caucasian, 47% African American, 6% biracial) and their parents completed intake assessments and were randomly assigned to Individual and Parent CBT (N= 25) or Family Therapy (N=18) using a process designed to stratify for child age, gender, and family constellation. Both groups received an average of 19 weeks of treatment. An additional 12 maltreated children and their guardians were referred for Routine Community Services (comparison group). Physical abuse had been reported for all children within the last 6 months. Participants were referred by CPS, community agencies, or were self-referred. 89% of the children were abused by a biological parent. Histories of substance use among caregivers were moderately common. 44 parent-child dyads completed post-treatment assessments immediately after treatment. Follow-up assessments were conducted at 3-month and 1-year after intervention completion.</p> <p><b>Outcome Measures:</b> Parent and child violence and</p>	

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	<p>child abuse risk were assessed via parent and child reports using the Conflict Tactics Scale (CTS) and the Weekly Report of Abuse Indicators (i.e., severity of identified family problems, levels of anger, threat or use of physical force). Parents also completed the Abuse Potential Inventory (API). Children's abuse-related responses (e.g., fears, perceptions, and problematic attributions) were measured by a subset of items from the Sexual Abuse Fear Evaluation (SAFE) and the Children's Attributions and Perceptions Scale (CAPS). Children's social, behavioral, and psychological adjustment was obtained via children's self-report on the Youth Self Report, the Children's Depression Inventory (CDI), the Children's Hostility Inventory (e.g., aggression), and the Child Conflict Index (CCI) which assesses problems experienced in past 24 hours. Parents completed the Child Behavior Checklist (CBCL) to provide information about children's externalizing (e.g., conduct problems) and internalizing (e.g., sadness, worry) difficulties, and research associateds completed the Global Assessment Scale for Children (Kiddie-GAS) after completing a phone interview with parents. Parents' psychological adjustment and parenting perceptions and practices were obtained via self reports, including the Brief Symptoms Inventory (BSI, e.g., parental distress), the Beck Depression Inventory (BDI), the discipline and child acceptance scales of the Child Rearing Interview (CRI) and the Parenting Scale of ineffective parenting practices. Finally children and parents completed measures to evaluate family functioning, including family cohesion and conflict as measured by the Family Environment Scale (FES) and general functioning, obtained from the Family Assessment Device (FAD). The Conflict Behavior Questionnaire (CBQ) was used to asses levels of hostility within the family. Researchers checked the child abuse registry to examine reports of abuse from intake to 1 year follow-up. To determine continuing needs of families or abuse concerns, parents, therapists, and caseworkers completed the Evaluation of Termination Status . Finally, several measures of children's and parent's satisfaction and</p>	

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	<p>perceived benefits of treatment.</p> <p><b>Reference:</b>            Kolko, D. J. (1995). Individual Cognitive Behavioral Treatment and Family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. <i>Child Maltreatment, 1</i>, 322-342.</p>	
<p><b>Is this Program an Evidence-Based Practice in other Family/ Youth Development Areas?</b></p>	<p>No</p>	
<p><b>Sources</b></p>	<p>Empirical Studies (peer-reviewed journal)            California Clearing House            Other (describe): Conference presentation</p>	

## Contact Information

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## Selected References & Helpful Links

Kolko, D. (2009). Alternatives for Families: A Cognitive-Behavioral Treatment. Paper presented at the *Children's Justice Conference, Seattle, WA*.

Kolko, D. (1996a). Individual cognitive behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment*, 1(4), 322-342.

Kolko, D. J. (1996b). Clinical monitoring of treatment course in child physical abuse: Psychometric characteristics and treatment comparisons. *Child Abuse and Neglect*, 20(1), 23-43.

[www.childwelfare.gov/pubs/cogntive](http://www.childwelfare.gov/pubs/cogntive).

<http://www.afcbt.org>

<http://www.partnershipsforfamilies.org>