

Alternatives for Families: A Cognitive- Behavioral Therapy (AF-CBT)

Families that experience conflict, coercion,¹ and/or physical abuse create substantial risk to children for the development of significant psychiatric, behavioral, and adjustment difficulties, including aggression, poor interpersonal skills/functioning, and emotional reactivity. Caregivers in such families often report punitive or excessive parenting practices, frequent anger and hyperarousal, and negative child attributions, among other stressful conditions. During the past four decades, research has documented the effectiveness of several behavioral and cognitive-behavioral methods, many of which have been

¹ Coercive parenting refers to parenting by domination, intimidation, or humiliation to force children to behave according to (often unrealistic) norms set by parents.

What's Inside:

- What makes AF-CBT unique?
- Treatment phases and key components
- Target population
- Effectiveness of AF-CBT
- What to look for in a therapist
- Resources for more information



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incorporated in alternatives for families: a cognitive-behavioral therapy (AF-CBT).

AF-CBT is an evidence-supported intervention that targets (1) diverse individual child and caregiver characteristics related to conflict and intimidation in the home and (2) the family context in which aggression or abuse may occur. This approach emphasizes training in intra- and interpersonal skills designed to enhance self-control and reduce violent behavior. AF-CBT has been found to improve functioning in school-aged children, their parents (caregivers), and their families following a referral for concerns about parenting practices, including child physical abuse (Kolko, 1996a; Kolko, 1996b; Kolko, Iselin, & Gully, 2011), as well as a child's behavior problems (Kolko, et al., 2009; Kolko, Hoagwood, & Springgate, 2010; Kolko, Campo, Kilbourne, & Kelleher, 2012).

This issue brief is intended to build a better understanding of the characteristics and benefits of AF-CBT, formerly known as abuse-focused cognitive behavioral therapy (Kolko, 2004). It was written primarily to help child welfare caseworkers and other professionals who work with at-risk families make more informed decisions about when to refer children and their parents and caregivers to AF-CBT programs. This information also may help parents, foster parents, and other caregivers understand what they and their children can gain from AF-CBT and what to expect during treatment. In addition, this issue brief may be useful to others with an interest in implementing or participating in effective strategies for the treatment of family conflict, child physical abuse, coercive parenting, and children with externalizing behavior problems.

What Makes AF-CBT Unique?

AF-CBT is designed to intervene with families referred for conflict or coercion, verbal or physical aggression by caregivers (including the use of excessive physical force or threats), behavior problems in children/adolescents, or child physical abuse. The treatment program has been expanded to accommodate children and adolescents with physical abuse or discipline-related trauma symptoms, such as posttraumatic stress disorder (PTSD).

AF-CBT addresses both the risk factors and the consequences of physical, emotional, and verbal aggression in a comprehensive manner. Thus, AF-CBT seeks to address specific clinical targets among caregivers that include heightened anger or hostility, negative perceptions or attributions of their children, and difficulties in the appropriate and effective use of parenting practices, such as ineffective or punitive parenting practices. Likewise, AF-CBT targets children's difficulties with anger or anxiety, trauma-related emotional symptoms, poor social and relationship skills, behavioral problems that include aggression, and dysfunctional attributions. At the family level, AF-CBT addresses coercive family interactions by teaching skills to improve positive family relations and reduce family conflict.

Reflects a Comprehensive Treatment Strategy

The diversity of family circumstances and individual problems associated with family conflict points to the need for a comprehensive treatment strategy that targets both the contributors to caregivers' behavior

and children's subsequent behavioral and emotional adjustment (Chadwick Center, 2004). Treatment approaches that focus on several aspects of the problem (for example, a caregiver's parenting skills, a child's anger, family coercion) may have a greater likelihood of reducing re-abuse and more fully remediating mental health problems (Kolko & Swenson, 2002). Therefore, AF-CBT adopts a comprehensive treatment strategy that addresses the complexity of the issues more completely.

Integrates Several Therapeutic Approaches

AF-CBT combines elements drawn from the following:

- **Cognitive therapy**, which aims to change behavior by addressing a person's thoughts or perceptions, particularly those thinking patterns that create distorted views
- **Behavioral and learning theory**, which focuses on modifying habitual responses (e.g., anger, fear) to identified situations or stimuli
- **Family therapy**, which examines patterns of interactions among family members to identify and alleviate problems, and offers strategies to help reframe how problems are viewed
- **Developmental victimology**, which describes how the specific effects of exposure to traumatic or abusive experiences may vary for children at different developmental stages and across the life span
- **Psychology of aggression**, which describes the processes by which aggression and coercion develop and are maintained,

which can help to understand one's history as both a contributor to and victim of aggressive behavior

AF-CBT pulls together many techniques currently used by practitioners, such as behavior and anger management, affect regulation, problem-solving, social skills training, cognitive restructuring, and communication. The advantage of this program is that all of these techniques, relevant handouts, training examples, and outcome measures are integrated in a structured approach that practitioners and supervisors can easily access and use.

Treats Children and Parents Simultaneously

During AF-CBT, school-aged children (5-15) and their caregivers participate in separate but coordinated therapy sessions, often using somewhat parallel treatment materials. In addition, children and parents attend joint sessions together at various times throughout treatment. This approach seeks to address individual and parent-child issues in an integrated fashion.

Discourages Aggressive or Violent Behavior

The AF-CBT approach is designed to promote appropriate and prosocial behavior, while discouraging coercive, aggressive, or violent behavior from caregivers as well as children. Consistent with cognitive-behavioral approaches, AF-CBT includes procedures that target three related ways in which people respond to different circumstances:

- Cognition (thinking)
- Affect (feeling)
- Behavior (doing)

AF-CBT includes training in various psychological skills in each of these response channels that are designed to promote self-control and to enhance interpersonal effectiveness.

Tailors Treatment to Meet Specific Needs and Circumstances

AF-CBT begins with a multisource assessment to identify the nature of the problems the child is experiencing, specific parental and family difficulties that may be contributing to family conflict, and the child's and family's strengths that may help influence change. Tailoring the treatment to the family's specific strengths and challenges is key to efficient outcomes (Kolko & Swenson, 2002).

Treatment Phases and Key Components

AF-CBT is a short-term treatment typically provided once or twice a week, which may require 18 to 24 hours of service (or longer, based on individual needs) over 4 to 12 months (although treatment may last as long as determined necessary). Treatment includes separate individual sessions with the child and caregiver/parent and joint sessions with at least both of them. Where necessary, family interventions may be applied before, during, or after the individual services. The treatment program for children, caregivers, and families incorporates the use of specific skills, role-playing exercises, performance feedback, and home practice exercises.

Generally, the goals of AF-CBT treatment are to:

- Reduce conflict and increase cohesion in family
- Reduce use of coercion (hostility, anger, verbal aggression, threats) by the caregiver and other family members
- Reduce use of physical force (aggressive behavior) by the caregiver, child, and, as relevant, other family members
- Promote nonaggressive (alternative) discipline and interactions
- Reduce child physical abuse risk or recidivism (prevention of child welfare system involvement or repeated reports/allegations)
- Improve the level of child's safety/welfare and family functioning

Treatment Phases

AF-CBT includes three treatment phases, each with key content that is designed to be relevant for both the caregiver and child. The sequence for conducting the treatment generally proceeds from teaching intrapersonal (e.g., cognitive, affective) skills first, followed by interpersonal skills (e.g., behavioral). Topics/sessions can be flexibly delivered (adapted, abbreviated, or repeated) based on the family's progress and/or treatment needs/goals in each phase. Although AF-CBT has primarily been used in outpatient and home settings, the treatment has been more recently delivered in inpatient and residential settings when there is some ongoing or potential contact between the caregiver and the child. The primary content in each topic noted below is organized into three phases reflected in the acronym *A-L-T-E-R-N-A-T-I-V-E-S*.

PHASE I: ENGAGEMENT and PSYCHOEDUCATION

- TOPIC 1: Orientation–Caregiver and Child
- TOPIC 2: **A**lliance Building and Engagement–Caregiver
- TOPIC 3: **L**earning About Feelings and Family Experiences–Child
- TOPIC 4: **T**alking About Family Experiences and Psychoeducation–Caregiver

PHASE II: INDIVIDUAL SKILL-BUILDING (Skills Training)

- TOPIC 5: **E**motion Regulation–Caregiver
- TOPIC 6: Emotion Regulation–Child
- TOPIC 7: **R**estructuring Thoughts–Caregiver
- TOPIC 8: Restructuring Thoughts–Child
- TOPIC 9: **N**oticing Positive Behavior–Caregiver
- TOPIC 10: **A**ssertiveness and Social Skills–Child
- TOPIC 11: **T**echniques for Managing Behavior–Caregiver
- OPTIONAL TOPIC 12: **I**maginal Exposure–Child
- TOPIC 13: Preparation for Clarification–Caregiver

PHASE III: FAMILY APPLICATIONS

- TOPIC 14: **V**erbalizing Healthy Communication–Caregiver and Child
- TOPIC 15: **E**nhancing Safety Through Clarification–Caregiver and Child
- TOPIC 16: **S**olving Family Problems–Caregiver and Child
- TOPIC 17: Graduation–Caregiver and Child

Key Components

AB-CBT includes specific therapy elements for children, parents, and families.

Treatment for School-Aged Children. The school-aged child-directed therapy elements include:

- Promoting engagement and treatment motivation by identifying individualized goals
- Identifying the child’s exposure to and views of positive experiences and upsetting ones (family hostility, coercion, and violence), including the child’s perceptions of the circumstances and consequences of the physical abuse or other conflict
- Educating the child on topics related to child welfare, safety/protection, service participation, and common reactions to abuse and family conflict
- Training in techniques to identify, express, and manage emotions appropriately (e.g., anxiety management, anger control)
- Processing the child’s exposure to incidents involving force or family conflict to understand and challenge any dysfunctional thoughts/views that encourage the use of aggression or support self-blame for these situations
- Training in interpersonal skills to enhance social competence and developing social support plans
- For those with significant PTS symptoms, conducting imaginal exposure and helping to articulate the meaning of what happened to the child

Treatment for Parents (or Caregivers).

Parent-directed therapy elements include:

- Education about relevance of the CBT model and physical abuse
- Establishing a commitment to limit physical force
- Encouraging discussion of any incidents involving the use of force within the family
- Reviewing the child's exposure to emotional abuse in the family and providing education about the parameters of abusive experiences (causes, characteristics, and consequences) in order to understand the context in which they occurred
- Teaching affect management skills to help identify and manage reactions to abuse-specific triggers, heightened anger, anxiety, and depression to promote self-control
- Identifying and addressing cognitive contributors to abusive behavior in caregivers (i.e., misattributions, high expectations, etc.) and/or their consequences in children (i.e., views supportive of aggression, self-blame, etc.) that could maintain any physically abusive or aggressive behavior
- Teaching parents strategies to support the child and encourage positive behavior using active/listening attention, praise, and rewards
- Training in effective discipline guidelines and strategies (e.g., planned ignoring, withdrawal of privileges, time out,) as alternatives to the use of physical force
- If the caregiver is ready, working on a clarification letter to be read to the child

Treatment for Families (or the Parent and Child).

Parent-child or family therapy elements include:

- Conducting a family assessment using multiple methods and identifying family treatment goals
- Encouraging a commitment to increasing the use of positive behavior as an alternative to the use of force
- Conducting a clarification session in which the caregiver can support the child by providing an apology, taking responsibility for the abuse/conflict, and showing a commitment to safety plans and other rules in order to keep the family safe and intact
- Training in communication skills to encourage constructive interactions
- Training in nonaggressive problem-solving skills with home practice applications
- Involving community and social systems, as needed

Target Population

AF-CBT is most appropriate for use with physically, emotionally, and/or verbally abusive or coercive parents and their school-aged children (Kolko, 1996a; Kolko, 1996b). AF-CBT has also been adapted for children diagnosed with behavior problems or disorders, including conduct disorder and oppositional defiant disorder (Kolko, Dorn, et al., 2009). Often, the children experience behavioral dysfunction, especially aggression, as a result of abuse. AF-CBT may also help high-conflict families who are at-risk for physical abuse/aggression.

Thus, AF-CBT is recommended for use with families that exhibit any or all of the following:

- Caregivers whose disciplinary or management strategies range from mild physical discipline to physically aggressive or abusive behaviors, or who exhibit heightened levels of anger, hostility, or explosiveness
- Children who exhibit significant externalizing or aggressive behavior (e.g., oppositionality, antisocial behavior), with or without significant physical abuse/discipline related trauma symptoms (e.g., anger, anxiety, PTSD)
- Families who exhibit heightened conflict or coercion or who pose threats to personal safety

Limitations for Use of AF-CBT

Parents with psychiatric disorders that may significantly impair their general functioning or their ability to learn new skills (e.g., substance use disorders, major depression) may benefit from alternative or adjunctive interventions designed to address these problems (Chadwick Center, 2004). In addition, children or parents with very limited intellectual functioning, or very young children, may require more simplified services or translations of some of the more complicated treatment concepts. Children with psychiatric disorders such as significant attention-deficit disorder or major depression may benefit from additional interventions. Sexually abused children may respond better to trauma-focused therapy. For more information, see Child Welfare Information Gateway's *Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma*: <https://www.childwelfare.gov/pubs/trauma>.

Effectiveness of AF-CBT

The effectiveness of AF-CBT is supported by a number of outcome studies, and AF-CBT has been recognized by other experts as a “model” or “promising” treatment program.

Demonstrated Effectiveness in Outcome Studies

During the past four decades, many of the procedures incorporated into AF-CBT have been evaluated by outside investigators as effective in:

- Improving child, parent, and/or family functioning
- Promoting safety and/or reducing abuse risk or re-abuse among various populations of parents, children, and families

These procedures have included the use of stress management and anger-control training, cognitive restructuring, parenting skills training, psychoeducational information regarding the use and impact of physical force and hostility, social skills training, imaginal exposure, and family interventions focusing on reducing conflict (see Kolko, 2002; Kolko & Kolko, 2009; Urquiza & Runyon, 2010).

Foundational studies by Kolko (1996a, 1996b) showed the effectiveness of the individual components of AF-CBT when compared to routine community services with abusive families in terms of improved child, parent, and family outcomes. A more recent study by Kolko, Iselin, and Gully (2011) documents the sustainability and clinical benefits of AF-CBT in an existing community clinic serving physically abused children and their families.

Key AF-CBT outcomes from the literature are summarized in the exhibit on the next page.

Recognition as an Evidence-Based Practice

Based on systematic reviews of available research and evaluation studies, several groups of experts and agencies have highlighted AF-CBT as a model program or promising treatment practice:

- AF-CBT is rated a 3, which is a Promising Practice, by the California Evidence-Based Clearinghouse for Child Welfare (<http://www.cebc4cw.org>).
- AF-CBT is featured in the Chadwick Center's (2004) *Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices* (<http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTA brochure.pdf>).
- AB-CBT is featured in *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project*, published by the National Child Traumatic Stress Network and the Medical University of South Carolina (de Arellano, Ko, Danielson, & Sprague, 2008).
- It is approved as an evidence-based treatment (EBT) by the Los Angeles County Office of Mental Health.
- It is included in EBT dissemination efforts being conducted by the Effective Providers for Child Victims of Violence Program of the American Psychological Association (<http://www.apa.org/pi/prevent-violence/programs/child-victims.aspx>).
- AF-CBT is included as a promising EBT in the website maintained by the U. S. Office of Justice Programs (<http://crimesolutions.gov/ProgramDetails.aspx?ID=107>).
- It is included in EBT dissemination activities by the Defending Childhood Initiative sponsored by the Attorney General's Office, U. S. Department of Justice.
- It is currently being disseminated by the National Child Traumatic Stress Network (NCTSN) in a National Learning Collaborative on AF-CBT.

What to Look for in a Therapist

Caseworkers who are considering a family's referral for AF-CBT should become knowledgeable about commonly used treatments before recommending a treatment provider to families. Parents or caregivers should receive as much information as possible on the treatment options available to them. If AF-CBT appears to be an appropriate treatment model for a family, the caseworker should look for a provider who has received adequate training, supervision, and consultation in the AF-CBT model. If feasible, both the caseworker and the family should have an opportunity to interview potential AF-CBT therapists prior to beginning treatment. AF-CBT can be provided in multiple settings—in the home, in clinics, or other community settings—and the average length of services varies depending on the client's needs, goals, and progress. Relevant information may also be available on the AF-CBT website (<http://www.afcbt.org>).

Summary of AF-CBT Outcomes

Parent Outcomes

- Achievement of individual treatment goals related to the use of more effective discipline methods
- Decreased parental reports of overall psychological distress
- Lowered parent-reported child abuse potential (risk)
- Reduction in parent-reported drug use

Child Outcomes

- Reduction in parent-reported severity of children’s behavior problems (externalizing behavior), including child-to-parent aggression and likelihood of violating other children’s privacy
- Reduction in child anxiety
- Greater child safety from harm

Family Outcomes

- Greater child-reported family cohesion
- Reduced child-reported and parent-reported family conflict

Child Welfare Outcome

- Low rate of abuse recidivism or concerns about the child being harmed

AF-CBT Training

Mental health professionals with at least some advanced training in psychotherapy skills and methods and experience working with physically abusive caregivers and their children are eligible for training in AF-CBT. Training generally involves:

- An initial didactic workshop training (3 days)
- Follow-up case consultation calls during “action plan” periods (6-12 months)
- Review of session performance samples for integrity/competency

- Booster retraining and advanced case review (1 day)
- Review of community metrics and progress report

See Training and Consultation Resources, below, for contact information.

Questions to Ask Treatment Providers

In addition to appropriate training and thorough knowledge of the AF-CBT model, it is important to select a treatment provider who is sensitive to the particular needs of

the child, caregiver, and family. Caseworkers recommending an AF-CBT therapist should ask the treatment provider to explain the course of treatment, the role of each family member in treatment, and how the family's specific cultural considerations will be addressed. The child, caregiver, and family should feel comfortable with and have confidence in the therapist.

Some specific questions to ask regarding AF-CBT include:

- Will the child and parent each receive individualized therapy using corresponding (coordinated) treatment protocols?
- Will social learning principles be used to address the thoughts, emotions, and behaviors of the child and parent?
- Is there a focus on enhancing the parent-child relationship and improving parental discipline practices?
- Is the practitioner sensitive to the cultural background of the child and family?
- Is there a standard assessment process used to gather baseline information on the functioning of the child and family and to monitor their progress in treatment over time?
- Is this the most appropriate treatment for this child and family?

Conclusion

AF-CBT is an evidence-supported treatment intervention for parents and school-aged children in families in which physical, emotional, or verbal abuse or family conflict has occurred. AF-CBT uses an integrated approach to address beliefs about abuse

and violence and improve skills to enhance emotional control and reduce violent behavior. Improvements resulting from the use of AF-CBT include reductions in the risk of child abuse, fewer abuse-related behavior problems in children, and improvements in family cohesion. Increased awareness of this treatment option among those making referrals, coupled with increased availability, may create opportunities for helping to strengthen families and reduce the risks for and consequences of child physical abuse.

Resources for More Information

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Training and Consultation Resources

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Clinicians are encouraged to read the following book:

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. (Available from <http://www.sagepub.com>)

The latest AF-CBT session guide and handouts (version 3; 11-1-2011) are described on the AF-CBT website (<http://www.afcbt.org>), which also includes training opportunities and research updates.

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