



AN OVERVIEW:

ALTERNATIVES FOR FAMILIES: A COGNITIVE BEHAVIORAL THERAPY (AF-CBT)

PROGRAM SUMMARY

Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT) is a behavioral family intervention for families who exhibit or are at risk for problems with anger, aggression, and/or child physical abuse (see www.afcbt.org). AF-CBT seeks to improve relationships between school-aged children and their parents/caregivers using a comprehensive approach that targets the risks for conflict and coercion and the clinical consequences of its exposure. Appropriate cases include caregivers who report the use of ineffective discipline and high rates of child behavior problems, and children who may experience traumatic reactions secondary to physical force/abuse. The program is rated as Promising. Following AF-CBT, parents have reported less child-to-parent and parent-to-child violence, children have shown fewer externalizing symptoms and improved social competence, and families have reported less conflict and more cohesion. Other outcomes include greater perceptions of child safety, lowering risk for child physical abuse and repeated abuse.

PROGRAM DESCRIPTION

PROGRAM GOALS

Alternatives for Families: Cognitive Behavioral Therapy (AF-CBT) is a comprehensive approach for reducing or preventing the effects of child physical abuse, exposure to child or family aggression, and hostile family environments. Accordingly, it targets many of the known risk factors for physical abuse/violence while also helping families to recover from the effects of exposure to verbal or physical aggression. AF-CBT teaches parents and children intrapersonal and interpersonal skills to enhance self-control, promote positive family relations, and reduce violent behavior. These skills include the use of positive coping and self-control skills, managing angry outbursts, child social skills, effective and safe discipline strategies, and healthy family problem solving and communication skills, ultimately improving child behavior and well-being, helping families get along better, and maintaining a safe and secure home environment.

TARGET POPULATION

AF-CBT is designed to work with a broad range of families engaged in verbal and/or physical aggression, whether the referral focuses upon the caregiver who is angry, the child who has behavior problems (e.g., ODD, CD), or the volatile or “at-risk” family. A family with any of the following may be eligible for AF-CBT:

- 1) A family or caregiver and child who experience frequent conflicts, arguments, angry feelings, or explosiveness.
- 2) A caregiver who uses or has used harsh physical force or discipline, or worries about doing something that could injure/hurt a child, or has a history of physical or emotional abuse involving one of his/her children.
- 3) A child (5-17 years old) who exhibits challenging behaviors such as not listening, fighting, hard to manage, or who shows trauma symptoms (e, g., posttraumatic stress) related to #1 or #2 above.

Many eligible families who receive AF-CBT also experience other challenges such as living in different residences, domestic disputes, substance use, incarceration, and/or prior traumatic experiences.

PROGRAM THEORY

AF-CBT draws elements from several conceptual or treatment models, including cognitive therapy, behavioral and learning theory, family therapy, developmental victimology, and the psychology of aggression.

- Behavioral and Learning Theory
 - Focuses on modifying habitual responses (anger or fear) to identified situations or stimuli.
- Cognitive Therapy
 - Aims to change behavior by promoting accurate/helpful views/beliefs (thinking patterns) that support safety.
- Family Therapy
 - Examines patterns of interactions among family members to identify and alleviate problems; also offers strategies to help reframe how problems are viewed.
- Developmental Victimology
 - 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
 - Emphasizes the importance of understanding psychological and physical aggression in the family, reciprocal interaction patterns, and the effects of these interactions on family members.

PROGRAM COMPONENTS AND CONTENT

Caregivers and children receive both joint and individual skills-training sessions to promote a set of complementary inter- and intra-personal competencies.

AF–CBT consists of 3 phases of treatment and 18 session components designed for both the caregiver and the child. Phase 1 concentrates on introduction to and engagement in treatment, psychoeducation, feeling identification, and abuse discussion. Phase 2 teaches new ways of thinking, emotional and behavior management, and how to get along with others. Phase 3 prepares the caregiver and child for program completion by holding a clarification meeting and teaching problem-solving techniques to use in future situations.

There are 18 topical content areas or components, including initial orientation and graduation that are delivered across three treatment phases. These topics are reflected in the acronym, **ALTERNATIVES**:

PHASE 1: ENGAGEMENT & PSYCHOEDUCATION

Alliance Building and Engagement

- Importance of promoting engagement and the development of a working relationship with the caregiver.

Learning about Feelings and Family Experiences

- Learn more specifically from the child about the referral incident/conflict, its circumstances, and its effects or consequences.

Talking about Family Experiences and Psychoeducation

- Get caregiver’s perspective on the incident.
- Learn caregiver’s views about and use of physical discipline/force, and the extent to which these appear to be modifiable.

PHASE 2: INDIVIDUAL SKILL BUILDING

Emotion Regulation

- Help caregiver identify and control heightened anger and/or anxiety.
- Discuss strategies children/teens can use to maintain self-control and appropriate behavior when frustrated or stressed.

Restructuring Thoughts

- Help the caregiver recognize, identify, and modify the types of unhelpful or negative thoughts when they have difficult experiences.
- Cognitive coping to teach the child new tools to address reactions and negative thoughts.

Noticing Positive Behavior

- Caregiver's use of positive consequences (e.g., praise, rewards, differential reinforcement) to promote desirable behavior.

Assertiveness and Social Skills

- Promote child's social competence.

Techniques for Managing Behavior

- Techniques for managing dangerous or destructive behaviors of child.

Imaginal Exposure

- Conduct imaginal exposure with child who has symptoms of PTSD or who is anxious when discussing or thinking about the referral incident and other experiences of conflict in the home.

PHASE 3: FAMILY APPLICATIONS

Verbalizing Healthy Communication

- Discuss how caregiver and child communicate with one another and ways to alter the kinds of verbal and non-verbal behaviors that each of them routinely use, in an effort to maximize communication.

Enhancing Safety through Clarification

- Caregiver will take responsibility, apologize, and indicate how the home will be made safer and more comfortable.
- Child will listen and respond, or ask questions.

Solving Family Problems

- Expose to family steps that can be followed in order to solve problems in non-aggressive ways.

EVALUATION OUTCOMES

STUDY 1

VIOLENT/AGGRESSIVE BEHAVIOR, FAMILY CONFLICT, AND CHILD ABUSE RISK

Kolko (1996) found that parents reported significantly less child-to-parent and parent-to-child violence over time in the individual Cognitive Behavioral Therapy (CBT) and Family Therapy (FT) groups, compared with the routine community service (RCS) group. Though both treatment groups showed a consistent reduction in child abuse risk potential, this only approached significance. In comparison, the RCS group had a small drop followed by a large increase in risk potential. CBT parents reported thinking of using physical force or discipline significantly less from pretreatment to posttreatment and at the 1-year follow-up than those in the RCS group. FT parents thought significantly less about using force from pretreatment to posttreatment only.

Children reported a significant reduction over time in parental anger and reported lower ratings of serious family problems over time for the treatment groups. However, there was no significant change in the number of threats or acts involving physical force.

RE-ABUSE

The rates for recidivism were 5% (CBT), 6% (FT), and 30% (RCS), but the differences were not statistically significant. One of the seven cases was for physical abuse; the other six were for maltreatment.

CHILD BEHAVIOR AND ADJUSTMENT

Children in both treatment groups reported significant reductions over time for internalizing and externalizing symptoms. There was no effect found for social skills. Scores on depression were generally low and did not differ significantly between groups. Parents reported significant reduction over time in levels of externalizing symptoms. Children from the CBT group showed the greatest initial change, and those from the FT group showed the greatest change at follow-up, compared with the RCS children.

PARENTING SKILLS AND FAMILY FUNCTIONING

CBT and FT parents reported significant reductions in belief in the need for physical punishment. There was a weak significant increase in level of discipline and in child acceptance.

Parents and children reported a significant increase in cohesion scores for the CBT and FT families. Children noted a significant decrease in conflict scores for the FT group as well. There was a significant reduction in the level of family conflict over time as reported by the parents in both treatment groups; conversely, the RCS group saw a significant increase.

STUDY 2

In Kolko (1996b), summaries of weekly reports of abuse indicators were obtained from the CBT and Family therapy conditions.

PARENTAL ANGER & PHYSICAL DISCIPLINE

Reports of parental anger and the use of force during treatment were found to decrease for both groups. However, the decline was significantly faster for the individual CBT condition than for the Family Therapy condition. The study provides empirical justification for monitoring and then addressing potential indicators of potential abusive behavior during treatment.

STUDY 3

CLINICAL AND FUNCTIONAL IMPROVEMENTS

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. The two AF-CBT content scores were differentially related to several of these outcomes. 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.

STUDY 4

In a study by Kolko et al. (2009), clinicians either in the community (COMM) or a clinic office (CLINIC) showed significant and comparable improvements on all outcomes.

IMPROVEMENTS IN CHILD BEHAVIOR PROBLEMS

By 3-year follow-up, 36% of COMM and 47% of CLINIC patients no longer met criteria for either ODD or CD, and 48% and 57% of the children in these two respective conditions had levels of parent-rated externalizing behavior problems in the normal range. These findings bear implications for understanding the role of treatment context or setting for the use of the general content AF-CBT in promoting the long-term outcome of behavior disorders.

STUDY 5

A study by Kolko et al. (2009) extended the use of AF-CBT to pediatric primary settings. Sites were randomized to receive a Protocol for On-site, Nurse-administered Intervention (PONI) that incorporated the general content of AF-CBT content or to Enhanced Usual Care (EUC).

SERVICE USE AND COMPLETION

PONI cases were significantly more likely to receive and complete mental health services, and reported fewer service barriers and more consumer satisfaction.

CHILD CLINICAL SYMPTOMS

PONI cases showed greater, albeit modest, improvements on just a few clinical outcomes that included remission for categorical behavioral disorders at one-year follow-up. Both conditions also reported several significant improvements on several clinical outcomes over time. A psychosocial intervention for behavior problems that was delivered by nurses in the primary care setting is feasible, improves access to mental health services, and has some clinical efficacy.

STUDY 6

SERVICE USE AND COMPLETION

Group comparisons found significant improvements for an extension of PONI that included the chronic care model (Doctor Office Collaborative Care, DOCC) over EUC in service use and completion, behavioral and emotional problems, individualized behavioral goals, and overall clinical response. Parent and pediatrician reports were highly satisfied with DOCC.

CHILD CLINICAL SYMPTOMS

DOCC cases showed greater, albeit modest, improvements on just a few clinical outcomes that included remission for categorical behavioral disorders at one-year follow-up. Both conditions also reported several significant improvements on several clinical outcomes over time. A psychosocial intervention for behavior problems that was delivered by nurses in the primary care setting is feasible, improves access to mental health services, and has some clinical efficacy. The feasibility and clinical benefits of DOCC for behavior problems supports the integration of collaborative mental health services for common mental disorders in primary-care.

STUDY 7

Kolko et al. (2012) conducted a randomized clinical trial with 182 practitioners randomized to AF-CBT training or to training as usual (TAU) to evaluate the dissemination of AF-CBT for family conflict/coercion, including child physical abuse.

DISSEMINATION OF AF-CBT TO COMMUNITY PRACTITIONERS

HLM analyses revealed significant initial improvements for those in the AF-CBT training condition in knowledge about AF-CBT and its targeted population, and use of AF-CBT teaching processes, abuse-specific skills, and general psychological skills. These findings

support brief treatment training models and the need to enhance work force stability as they relate to community practitioners representing diverse backgrounds, professional experiences, client populations, and service settings.

STUDY 8

In an extension of Kolko et al (2012), Kolko et al. (in press) conducted a randomized clinical effectiveness trial with 195 families who were seen by practitioners who were randomized to AF-CBT training or to training as usual (TAU) to evaluate the outcomes of these conditions. We also examined outcomes for referrals from the mental health (MHS) or child welfare system (CWS).

SERVICE USE AND DELIVERY

Providers trained in AF-CBT (vs. TAU) were more likely to treat families showing anger, aggression, or abusive behavior at all assessments. Those in the CWS were also more likely to target these problems during intervention.

CLINICAL OUTCOMES – ANGER, AGGRESSION, PARENTING, FAMILY FUNCTIONING

Using univariate tests and growth curve models, the analyses revealed improvements for AF-CBT (vs. TAU) on clinical outcomes in the short-term (i.e., child posttraumatic stress, family dysfunction) or long-term (i.e., achievement of overall individualized treatment goals) in both service systems. Some outcomes favored AF-CBT providers in MHS programs in the short-term (i.e., less child-to-parent minor assault, caregiver abuse risk, family conflict) or long-term (i.e., reduced child problems, parental threats of violence), whereas one favored AF-CBT among CWS programs in the long-term (e.g., achievement of aggression management goals). These improvements for AF-CBT were found on some child, parent, and family outcomes that reflected both general functioning and aggression-specific measures.

OFFICIAL CHILD WELFARE REPORTS

AF-CBT and TAU showed reductions in the rates of CPA reports alone or when combined with emotional abuse reports from the 2-year baseline period to the 18-month follow-up period, but the difference was only statistically significant for AF-CBT. Coincidentally, the 5% rate for physical abuse found at 18-months for AF-CBT parallels the 5% to 6% recidivism rates found for the same time interval reported for the individual CBT and family therapy conditions that were integrated in AF-CBT (Kolko, 1996a, 1996b).

EVALUATION METHODOLOGY

STUDY 1

Kolko (1996) randomly assigned 55 maltreated children and their guardians to one of the following interventions: Individual Child and Parent Cognitive Behavioral Therapy (CBT; n=25), Family Therapy (FT; n=18), or routine community service (RCS; n=12). The FT intervention taught families positive communication skills and how to solve problems by working together. The RCS control families were referred by caseworkers to appropriate local services on the basis of a risk assessment interview.

Families were included in the study if there had been a report of physical child abuse, of maltreatment, or of frequent or harsh physical force without injury in the past 6 months. Children were 6 to 13 years old, had no developmental or intellectual disorders, were not treated for sexual abuse in the past year, were not participating in similar treatment, were interested and willing to participate in therapy, and resided locally. Guardians had no intellectual or psychiatric disorders, were not involved in a similar treatment program, were interested and willing to participate in therapy, and resided locally.

This study evaluated the three groups using measures based on violence and abuse risk, child and parent dysfunction, cognitive behavioral techniques, and family functioning. Interviews were conducted before treatment, immediately after treatment, after 3 months and after 1 year.

STUDY 2

A companion report (Kolko, 1996b) compared the treatment course of the two randomized conditions (individual CBT vs. family therapy, FT) from the original outcome study (see Kolko, 1996a), weekly ratings of parents' use of physical discipline/force and anger problems were collected during each treatment session from children and their parents/caregivers using items developed for this client population (the Weekly Report of Abuse Indicators, WRAI).

STUDY 3

Kolko et al. (2011) reported a study that describes the long-term sustainability and outcome of Alternatives for Families: A Cognitive-Behavioral Therapy (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. 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.

STUDY 4

A study by Kolko et al. (2009) examined the treatment outcomes of 144, 6-11 year-old, clinically referred boys and girls diagnosed with Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) who were randomly assigned to a modular-based treatment protocol that was applied by research study clinicians either in the community (COMM) or a clinic office (CLINIC). The protocol was adapted from the key content modules in AF-CBT. To examine normative comparisons, a matched sample of 69 healthy control children was included. Multiple informants completed diagnostic interviews and self-reports at six assessment timepoints (pretreatment to 3-year follow-up) to evaluate changes in the child's behavioral and emotional problems, psychopathic features, functional impairment, diagnostic status, and service involvement. HLM and logistic regression models were used to examine treatment outcome.

STUDY 5

Kolko et al. (2010) determined the effectiveness of an on-site modular intervention (based on AF-CBT content) called PONI in improving access to mental health services and outcomes for children with behavioral problems in primary care relative to enhanced usual care. The primary clinical content of PONI for child behavior problems was based on the AF-CBT manual. Boys and girls from six primary care offices in metropolitan Pittsburgh, PA. *Participants:* One-hundred and sixty-three clinically referred children who met a modest clinical cutoff (75th percentile) on the externalizing behavior scale of the Pediatric Symptom Checklist-17 were randomized to a protocol for on-site, nurse-administered intervention (PONI) or to enhanced usual care (EUC). PONI applied treatment modules from an evidence based treatment for children with disruptive behavior disorders (AF-CBT) that were adapted for delivery in the primary care setting; EUC offered diagnostic assessment, recommendations, and facilitated referral to a specialty mental health provider in the community. Standardized rating scales, including the PSC-17, individualized target behavior ratings, treatment termination reports, and diagnostic interviews were collected.

STUDY 6

Kolko et al. (2012) conducted a study to evaluate the feasibility and clinical utility of an integrated behavioral health intervention (Doctor-Office Collaborative Care, DOCC) that incorporated the PONI intervention content (based on AF-CBT) and added collaborative care processes delivered by a care manager and primary care provider. DOCC was compared to Enhanced Usual Care (EUC) for children with behavior problems. The first two of every three eligible cases were assigned to DOCC ($n = 55$) and every third

case to EUC ($n = 23$). Initial assessment was conducted in one of six pediatric primary-care practices. Posttreatment assessment was conducted in the pediatric or research office. DOCC was delivered in the practice; EUC was initiated in the office but involved a facilitated referral to a local mental health specialist. Of 125 referrals (ages 5-12), 78 children participated. Children and their parents were assigned to receive DOCC or EUC. Pretreatment diagnostic status was evaluated on the Schedule for Affective Disorders and Schizophrenia for School-Aged Children. Pretreatment and 6-month posttreatment ratings of behavioral and emotional problems were collected from parents on the Vanderbilt ADHD Diagnostic Parent Rating Scale and Individualized Goal Achievement Ratings form. At discharge, care managers and an evaluator completed the Clinical Global Impression Scale, and both pediatricians and parents completed satisfaction and study feedback measures.

STUDY 7

Kolko et al (2012) conducted a clinical trial designed to evaluate the dissemination of AF-CBT in a sample of 182 practitioners randomized to AF-CBT training or training as usual (TAU). The practitioners completed measures reflecting the core content of AF-CBT (e.g., teaching processes, abuse-specific skills, general psychological skills), practice attitudes about evidence based programs, and organizational support scales at 4 timepoints (0, 6, 12, and 18 months post baseline). HLM analyses were used to document group differences.

STUDY 8

Using the same provider sample from study 7, Kolko et al. (in press) recruited families from 10 agencies whose programs were supported by referrals from the mental health or child welfare system. Individual providers were randomized to receive AF-CBT training ($n = 90$) in a 6-month learning community or Treatment as Usual (TAU; $n = 92$) which provided trainings per agency routine. We recruited families served by those providers in the AF-CBT ($n = 122$) and TAU ($n = 73$) conditions and collected multiple outcomes at up to 4 timepoints (0, 6, 12, and 18 months). Measures included service use and delivery, clinical outcomes related to child, caregiver, and family functioning (e.g., service use and targets, anger and aggression, family conflict) and official child welfare reports. These findings are relevant to an extension of the evidence in support of AF-CBT, the importance of service system, provider, and family characteristics, and the need for advanced training/dissemination methods that can affect the delivery of an EBT for this population in community settings.

TRAINING OPTIONS AND COSTS

Requirements: Clinicians implementing AF-CBT must have a minimum of a master's degree in mental health or related field and must be certified as a clinician, have a license, or be supervised by a licensed clinician who received training.

Learning Community Training Model: Training in AF-CBT follows a learning community model that includes various requirements and activities (e.g., training and booster sessions, delivery of AF-CBT to at least two cases, consultation calls, submission of audio files for review, case presentations, and caseload metrics). The specific components of the training model are outlined in the table below.

<h3>AF-CBT TRAINING MODEL</h3>	
LEARNING COMMUNITY	
PROGRAM/STAFF READINESS (1-2 MONTHS BEFORE TRAINING)	
1)	Agency readiness calls to prepare program leadership, supervisors, staff, and stakeholders
2)	Review of trainee pre-training evaluation and agency metrics (online reports)
3)	Development of training materials (slides) and exercises tailored to agency/population

- 4) Delivery of AF-CBT session guides (manual, handouts) and assessment tools, and a link to the online AF-CBT orientation video on the NCTSN website (www.NCTSN.org)

LEARNING COMMUNITY: INTENSIVE SKILLS-TRAINING

- 1) Basic Training workshop/experiential seminar on the use of AF-CBT for all trainees (2.5 days)
- 2) Advanced Training workshop, 6 months later (1/2 or full day; live or via web)
- 3) Case consultation calls with trainer (12-18 calls in 6-12 months) with 2 case presentations by each trainee
- 4) Fidelity monitoring feedback based on trainer reviews of digital audio files uploaded by each trainee to our secure website (2 files submitted/trainee)
- 5) Online access to the trainer for Q&A and to website for updated materials, staff support for online infrastructure and conference call system
- 6) Supervisor-only calls to promote effective AF-CBT supervision and delivery (4-6 calls)

PERFORMANCE REVIEW (AT END OF TRAINING)

- 1) Completion of post-training evaluation and agency metrics
- 2) Review of staff eligibility for Clinician Certification program with trainer
- 3) Program data summary of trainee and agency metrics evaluation (follow-up)

TRAINING OPTIONS AND COSTS:

There are four options for organizing or obtaining a training in AF-CBT: costs can be obtained by sending a question via the website.

AGENCY ON-SITE TRAINING FOR A GROUP OF STAFF (CLINICIANS, SUPERVISORS)

A national faculty member will conduct the training in your setting or community that is tailored to your program's needs. We encourage having a cohort of at least 12 trainees (up to 15) from one or more agencies to enrich the learning experience. A trainer can also accommodate a larger group (price varies based on number of trainees, logistics, and other parameters discussed in advance). Interested administrators or managers may request a training by completing our training request form (go to www.afcbt.org and click the training and certification tab).

TRAINING PROGRAM FOR AN INDIVIDUAL PRACTITIONER WHO TRAVELS TO A DESIGNATED TRAINER SITE

Most of these trainings have been conducted in Pittsburgh or Los Angeles. Descriptions and dates are posted in our website calendar.

TRAINING PROGRAM TO BECOME AN IN-HOUSE TRAINER IN AF-CBT

Agency staff who are certified as a AF-CBT clinician can apply to become an AF-CBT in-house trainer. This training program allows the trainer to conduct trainings in the agency for new staff with support from the national AF-CBT office. Please check <http://www.afcbt.org/certification/in-house-trainer> to find information about our in-house trainer program.

AGENCY TRAINING CONDUCTED BY THE AGENCY'S CERTIFIED IN-HOUSE TRAINER

Agency staff who are certified as an in-house trainer can conduct agency trainings in coordination with the national AF-CBT office. There is a small cost per training participant to cover the cost of all training and treatment materials, web and data infrastructure maintenance to facilitate ongoing website access to all materials/updates, and technology assistance (e.g., uploading audio). Please check <http://www.afcbt.org/certification/in-house-trainer> to find information about our in-house trainer program.

To sign up for an upcoming training for AF-CBT, please visit <http://www.afcbt.org/training/sign-up-for-training>

For information on training criteria for AF-CBT, please visit: <http://www.afcbt.org/training/trainingmodel>

For more information on AF-CBT certification process, please visit: <http://www.afcbt.org/certification/clinician>

IMPLEMENTATION INFORMATION

Trained practitioners have access to numerous materials to facilitate their delivery and implementation of AF-CBT which are available through the website. They include forms to help with clinical assessment and interpretation, treatment guidelines/manuals and handouts, in different languages, fidelity procedures, program monitoring, metrics, progress notes, and collaboration materials.

AF-CBT can be implemented in any setting. The most common places are clinics (outpatient and residential), home or other private residences, community centers, and foster programs. AF-CBT has also been applied in residential treatment programs and hospitals, schools, and other community-based settings.

An AF-CBT provider will tailor the material to a family's needs and set up a flexible schedule that is convenient for each participant. AF-CBT provides individual child, individual caregiver, and parent-child or family sessions. Any adult caregiver (biological, foster, adoptive, etc.) can participate with at least one child.

Many families are scheduled for weekly services delivered over a 6- to 9-month period. However, the duration of treatment and number of sessions may vary, due to factors such as the complexity of the case, or availability of resources, as well as family cooperation and participation. Thus, scheduling is flexible, but is guided by the needed to maximize attendance and participation.

Although AF-CBT research has been evaluated with Caucasian and African American families, it has also been used with American Indian, African, Hispanic, Caribbean, Haitian, Asian, and Asian American families.

EVIDENCE-BASED (STUDIES REVIEWED)

These sources were used in the development of the program profile:

STUDY 1

Kolko, David J. 1996a. "Individual Cognitive Behavioral Treatment and Family Therapy for Physically Abused Children and their Offending Parents: A Comparison of Clinical Outcomes." *Child Maltreatment* 1:322-42.

STUDY 2

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

STUDY 3

Kolko, D. J., Iselin, A. M., & Gully, K. (2011). Real-World" Application of AF-CBT in a Child Protection Center: A Naturalistic Evaluation of Sustainability and Clinical Outcome. *Child Abuse & Neglect*, 35, 105-116.

STUDY 4

Kolko, D. J., Dorn, L. D., Bukstein, O. G., Pardini, D., Holden, E. A., & Hart, J. D. (2009). Community vs. clinic-based modular treatment of children with early-onset ODD or CD: A clinical trial with three-year follow-up. *Journal of Abnormal Child Psychology*, 37, 591-609.

STUDY 5

Kolko, D. J., Campo, J. V., Kelleher, K., & Cheng, Y. (2010). Improving Access to Care and Clinical Outcome for Pediatric Behavioral Problems: A Randomized Trial of a Nurse-Administered Intervention in Primary Care. Journal of Behavioral and Developmental Pediatrics, 31, 393-404.

STUDY 6

Kolko, D. J., Campo, J. V., Kilbourne, A. & Kelleher, K. (2011). Doctor-Office Collaborative Care for Pediatric Behavior Problems: A Preliminary Clinical Trial. Archives of Pediatrics & Adolescent Medicine (online – first access).

STUDY 7

Kolko, D. J., Baumann, B. L., Herschell, A. D., Hart, J. A., & Wisniewski, S. (2012). Dissemination of AF-CBT to Community Practitioners Serving Mental Health and Child Welfare: A Randomized Trial. Child Maltreatment.

STUDY 8

Kolko, D. J., Herschell, A. D., Baumann, B. L., Hart, J. A., & Wisniewski, S. (in press). AF-CBT for Families Experiencing Physical Aggression or Abuse Served by the Mental Health or Child Welfare System: An Effectiveness Trial. Child Maltreatment.

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Kolko, D. J., & Berkout, O. (2017). Child physical abuse. In S. Gold, J. Cook, & C. Dalenberg (Eds.), *Handbook of Trauma Psychology* (pp. 99-116), American Psychological Association, Washington, DC.

Kolko, D. J., & Berkout, O. (2018). Child physical abuse. In B. Klika & J. Conte (Eds.), The APSAC handbook on child maltreatment (4th edition) (pp. 111-126). Thousand Oaks, CA: Sage Publications.

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