NCTSN The National Child Traumatic Stress Network

Abuse-Focused Cognitive Behavioral Therapy for Child Physical Abuse (AF-CBT)

Treatment Description	AF-CBT represents an approach to working with physically abused children and their offending caregivers that incorporates conceptual and therapeutic principles/procedures from several areas including learning/behavioral theory, family-systems, cognitive therapy, and developmental victimology. AF-CBT integrates several behavior therapy and CBT procedures that target individual child and parent characteristics related to the abusive experience and the larger family context in which coercion or aggression occurs. Thus, this approach can be used to address parent and family risks for/correlates of physical abuse and/or common sequelae exhibited by children following the abuse. Treatment emphasizes instruction in specific intrapersonal (e.g., cognitive, affective) and interpersonal (e.g., behavioral) skills designed to promote the expression of prosocial behavior and discourage the use of coercive/aggressive behavior at both the individual and family levels. For a detailed description, see 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.
Target Population	AF-CBT is appropriate for use with physically abusive/aggressive parents and their school-age children. Although it has been primarily used in outpatient settings, the treatment can be delivered on an individual basis in alternative residential settings, especially if there is some ongoing contact between caregiver and child. This approach is designed for caregivers who exhibit, for example, negative child perceptions, heightened anger or hostility, and/or harsh/punitive/ineffective parenting practices, or for families involved in verbally or physically coercive interactions. 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. Parents with serious psychiatric or personality impairments (e.g., substance use disorders, major depression,) may benefit from adjunctive and/or alternative interventions. In addition, children or parents with limited intellectual functioning, or very young children, may benefit from more simplified services or translations of key concepts. Children with psychiatric disorders (e.g. Attention Deficit Hyperactivity Disorder, Major Depressive Disorder,) may benefit from additional interventions, and traumatized children, especially sexually abused children, are more appropriate candidates for Trauma-Focused CBT.

Intensity	The delivery of treatment is organized into three phases: • Phase 1: Joining with Family/Setting the Stage • Phase 2: Skills Building – Individual and Family • Phase 3: Applications – Family Routines Treatment generally involves 12 to 18 hours of service over a period of 12 to 16 weeks and is applied in the clinic and home. Modalities of treatment have included parallel individual and family therapy sessions. Group treatment is also an option.
Essential Components	Child-directed components • Socialization to models of stress and CBT • Understanding and cognitive processing of the child's exposure to hostility/violence and abusive experience(s) • Psychoeducation about child abuse laws, child safety/welfare, and common abuse-related reactions/attributions • Training in affect identification, expression, and management skills (e.g., relaxation training, anger control) • Coping skills discussions (healthy vs. unhealthy coping) and training to address everyday problems (e.g., home, school) • Development of social support plans and interpersonal skills training to enhance social competence Caregiver/Parent-directed components • Socialization to models of stress and CBT • Discussion of family contributors to coercive behaviors • Cognitive processing/challenging of caregiver's views on hostility/violence, child-related developmental expectations, and attributions that may promote coercive interactions • Affect-regulation interventions to manage reactions to abuse-specific triggers (e.g., escalating anger, anxiety, or depression) • Training in behavior management principles and techniques to promote use of nonphysical but effective disciplinary practices • As appropriate, discussion of or training in any of the procedures described in the child section above Parent-Child or family-system components Where relevant, parent-child or family-system interventions may be applied separately or in the context of these individual services: • Development of no-violence contract and safety plans • Family assessment using multiple methods (rating scales, observations) and identification of family treatment goals • 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, supportive interactions • Nonaggressive problem-solving skills training to minimize coercion, with home practice applications to establish routines • Community and social system involvement, as needed

Assessment Measures Used	Several instruments may be used to evaluate factors in each of the following domains that may contribute to the risks for and/or consequences of child physical abuse (see Kolko and Swenson, 2002). An individualized assessment of this nature is encouraged to help the clinician better identify clinical targets for intervention: *Caregiver parenting practices, including the use of coercive, aggressive, or violent behaviors (e.g., harsh physical discipline) and positive management practice:* a. Weekly Report of Abuse Indicators (WRAI; Kolko, 1996a) b. Conflict Tactics Scales—Parent to Child version (CTSPC; Straus et al., 1998) c. Alabama Parenting Questionnaire (APQ; Shelton et al., 1996) *Child social skills, interpersonal effectiveness, social withdrawal:* a. Child Behavior Checklist (CBCL; Achenbach, 1991) b. Social Skills Rating Scale (SSRS; Gresham and Elliot, 1990) *Parental psychological distress and clinical targets* a. Brief Symptom Inventory (BSI; Derogatis et al., 1983) b. Parent Opinion Questionnaire (POQ; Azar, 1986) *Children's behavioral and emotional problems* a. Child Behavior Checklist (CBCL; Achenbach, 1991) b. Children's Hostility Inventory (CHI; Kazdin et al., 1987) c. Trauma Symptom Checklist-Children (TSCC; Briere, 1996). *Family functioning, especially levels of conflict and cohesion* a. Family Environment Scale (FES; Moos et al., 1974) b. Family Adaptability Scales-II (FACES-II; Olson et al., 1982)
Outcome Measures Used	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).
Training Requirements	Training is intended for mental health professionals with at least some advanced training in psychotherapy skills/methods and experience working with physically abusive caregivers and their children. Participants are encouraged to review a brief summary of the treatment approach beforehand; whenever possible, it is desirable to become familiar with the materials in the author's book, which provides more detail on assessment and treatment methods. In addition, a pretraining assessment survey has been administered to gain an understanding of therapist's practices and knowledge. Training generally involves at least six hours of didactic instruction. We strongly advise additional training experiences, including follow-up consultation and supervision on the implementation of AF-CBT with a small caseload; the duration of this experience may vary by level of experience and case difficulty (typical range: six to 18 hours over three to six mos.)

Fidelity Monitoring Procedures	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 by the author.
Implementation Requirements and Readiness	Clinicians are encouraged to review the book and maintain copies of relevant materials for efficient use during sessions. It is also helpful to develop tapes for later review during supervision. Clinicians who reach integrity ratings of 75 percent with at least two cases should be adequately competent to administer the treatment. Having a confidential space for conducting sessions, access to clinical supervision, and a system for monitoring and responding to clinical emergencies are important aspects of a clinician's general readiness for this work.
Outcomes/ Evaluation	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 and 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. In terms of overall outcomes through follow-up (Kolko, 1996b), both the individual CBT and family therapy conditions reported greater improvements than RCS on certain children (i.e., less child-to-parent aggression, child externalizing behavior,) parents (i.e., child abuse potential, individual treatment targets reflecting abusive behavior, psychological distress, drug use,) and family outcomes (i.e., less conflict, more cohesion.) Both CBT and family therapy had high consumer satisfaction ratings.
Adaptations for Special Populations or Settings	Descriptions of the materials included in the book 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.
Recent Publications	Kolko, D. J. (1996a). Clinical monitoring of treatment course in child physical abuse: Psychometric characteristics and treatment comparisons. *Child Abuse & Neglect, 20*, 23-43. Kolko, D. J. (1996b). 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.

Recent Publications Cont'd	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* (Second ed., pp. 21-54). Thousand Oaks, CA: Sage. 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
Treatment Developer	Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine
Contact Information	For more information on the AF-CBT model, contact, David J. Kolko, PhD 412-246-5888, kolkodj@upmc.edu, www.pitt.edu/~kolko, University of Pittsburgh School of Medicine.

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