CBT for Children Affected by Sexual Abuse or Trauma

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ISSUE BRIEF

August 2012

Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse or Trauma

Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based treatment approach shown to help children, adolescents, and their caregivers overcome trauma-related difficulties. It is designed to reduce negative emotional and behavioral responses following child sexual abuse, domestic violence, traumatic loss, and other traumatic events.[1] The treatment—based on learning and cognitive theories—addresses distorted beliefs and attributions related to the abuse and provides a supportive environment in which children are encouraged to talk about their traumatic experience. TF-CBT also helps parents who were not abusive to cope effectively with their own emotional distress and develop skills that support their children.

What's Inside:

[1] While TF-CBT is effective in addressing the effects of traumatic events (e.g., the loss of a loved one, domestic or community violence, accidents, hurricanes, terrorist attacks, etc.), the main focus of this issue brief is the treatment of child sexual abuse and exposure to other trauma.

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This issue brief is intended to build a better understanding of the characteristics and benefits of TF-CBT. 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 TF-CBT therapists. This information also may help biological parents, foster parents, and other caregivers understand what they and their children can gain from TF-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 children who have suffered from sexual abuse or multiple traumatic events.

Researchers and providers continue to develop and refine trauma treatment approaches and determine how to incorporate them into child welfare services. In September 2011, the Children's Bureau awarded 5-year cooperative agreements to five organizations to focus on integrating trauma-informed and trauma-focused practice in child protective service (CPS) delivery. The grantees will implement TF-CBT and several other therapies demonstrating some evidence of effectiveness with children and families who have experienced trauma.[2]

[2] The Children's Bureau does not endorse any specific treatment or therapy. Before implementing a specific type of therapy in your community, consider its appropriateness based on families' needs, resource availability, and fit within the current service delivery system. Read the section Considerations for Child Welfare Agency Administrators to determine if TF-CBT is right for your agency, and consult the section Resources for Further Information to identify and select therapies for the families you serve.

Features of TF-CBT

TF-CBT addresses the negative effects of sexual abuse, exposure to domestic violence and other traumatic events by integrating several therapeutic approaches and treating both child and parent in a comprehensive manner.

TF-CBT Addresses the Effects of Sexual Abuse and Trauma

In the immediate as well as long-term aftermath of exposure to trauma, children are at risk of developing significant emotional and behavioral difficulties (see, for example, Berliner & Elliott, 2002; Briere & Elliott, 2003; Chadwick Center, 2004). For example, victims of sexual abuse often experience:

- **Maladaptive or unhelpful beliefs and attributions** related to the abusive events, including:
  - A sense of guilt for their role in the abuse
  - Anger at parents for not knowing about the abuse
  - Feelings of powerlessness
  - A sense that they are in some way "damaged goods"
  - A fear that people will treat them differently because of the abuse
- **Acting out behaviors,** such as engaging in age-inappropriate sexual behaviors
- **Mental health disorders,** including major depression
- **Posttraumatic stress disorder (PTSD)** symptoms, which are characterized by:

- Intrusive and reoccurring thoughts of the traumatic experience
- Avoidance of reminders of the trauma (often places, people, sounds, smells, and other sensory triggers)
- Emotional numbing
- Irritability
- Trouble sleeping or concentrating
- Physical and emotional hyperarousal (often characterized by emotional swings or rapidly accelerating anger or crying that is out of proportion to the apparent stimulus)

These symptoms can impact the child's daily life and affect behavior, school performance, attention, self-perception, and emotional regulation.

To date, numerous studies have documented the effectiveness of TF-CBT in helping children overcome these and other symptoms following child sexual, domestic violence, and similar traumatic experiences (see Empirical Studies at end of paper). This treatment helps children to process their traumatic memories, overcome problematic thoughts and behaviors, and develop effective coping and interpersonal skills (see Effectiveness of TF-CBT, below).

TF-CBT Treats Nonoffending Parents in Addition to the Child

Recognizing the importance of parental support in the child's recovery process, TF-CBT includes a treatment component for parents (or caregivers) who were not abusive. Treatment sessions are divided into individual meetings for the children and parents, with about equal amounts of time for both. The parent component teaches stress management, parenting and behavior management skills, and communication skills. As a result, parents are better able to address their own emotional distress associated with the child's trauma, while also supporting their children more effectively.

TF-CBT Integrates Several Established Treatment Approaches

TF-CBT combines elements drawn from:

- **Cognitive therapy**, which aims to change behavior by addressing a person's thoughts or perceptions, particularly those thinking patterns that create distorted or unhelpful views
- **Behavioral therapy**, 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

TF-CBT uses well-established cognitive-behavioral therapy and stress management procedures originally developed for the treatment of fear, anxiety, and depression in adults (Wolpe, 1969; Beck, 1976). These procedures have been used with adult rape victims with symptoms of PTSD (Foa, Rothbaum, Riggs, & Murdock, 1991) and have been applied to children with problems with excessive fear and anxiety (Beidel & Turner, 1998). The TF-CBT protocol has adapted and refined these procedures to target the specific difficulties exhibited by children who are experiencing PTSD symptoms in response to sexual abuse, domestic violence, or other childhood traumas. In addition, well-established parenting approaches (e.g.,

Patterson, 2005; Forehand & Kotchick, 2002) also are incorporated into treatment to guide parents in addressing their children's behavioral difficulties.

TF-CBT Shows Results in Various Environments and Cultural Backgrounds

TF-CBT has been implemented in urban, suburban, and rural environments and in clinics, schools, homes, residential treatment facilities, and inpatient settings. TF-CBT has demonstrated effectiveness with children and families of different cultural backgrounds (including Caucasian, African-American, and Hispanic children from all socioeconomic backgrounds) (e.g., Weiner, Schneider, & Lyons, 2009). Therapy has been adapted for Latino, Native American, and hearing-impaired populations. It is a highly collaborative therapy approach in which the therapist, parents, and child all work together to identify common goals and attain them.

TF-CBT Is Appropriate for Multiple Traumas

Recent research findings suggest that TF-CBT is more effective than nondirective or client-centered treatment approaches for children who have a history of multiple traumas (e.g., sexual abuse, exposure to domestic violence, physical abuse, as well as other traumas) and those with high levels of depression prior to treatment (Deblinger, Mannarino, Cohen, & Steer, 2006). The model also has been tested with children who are experiencing traumatic grief after the death of a loved one (Cohen, Mannarino, & Knudsen, 2004; Cohen, Mannarino, & Staron, 2006).

Key Components

TF-CBT is a short-term treatment typically provided in 12 to 18 sessions of 50 to 90 minutes, depending on treatment needs. The intervention is usually provided in outpatient mental health facilities, but it has been used in hospital, group home, school, community, residential, and in-home settings.

The treatment involves individual sessions with the child and parent (or caregiver) separately and joint sessions with the child and parent together. Each individual session is designed to build the therapeutic relationship while providing education, skills, and a safe environment in which to address and process traumatic memories. Joint parent-child sessions are designed to help parents and children practice and use the skills they learned and for the child to share his/her trauma narrative while also fostering more effective parent-child communication about the abuse and related issues.

Goals

Generally, the goals of TF-CBT are to:

- Reduce children's negative emotional and behavioral responses to the trauma
- Correct maladaptive or unhelpful beliefs and attributions related to the traumatic experience (e.g., a belief that the child is responsible for the abuse)
- Provide support and skills to help nonoffending parents cope effectively with their own emotional distress
- Provide nonoffending parents with skills to respond optimally to and support their children

Protocol Components

Components of the TF-CBT protocol can be summarized by the word "PRACTICE":

- **P - Psychoeducation and parenting skills**—Discussion and education about child abuse in general and the typical emotional and behavioral reactions to sexual abuse; training for parents in child behavior management strategies and effective communication
- **R - Relaxation techniques**—Teaching relaxation methods, such as focused breathing, progressive muscle relaxation, and visual imagery
- **A - Affective expression and regulation**—Helping the child and parent manage their emotional reactions to reminders of the abuse, improve their ability to identify and express emotions, and participate in self-soothing activities
- **C - Cognitive coping and processing**—Helping the child and parent understand the connection between thoughts, feelings, and behaviors; exploring and correcting of inaccurate attributions related to everyday events
- **T - Trauma narrative and processing**—Gradual exposure exercises, including verbal, written, or symbolic recounting of abusive events, and processing of inaccurate and/or unhelpful thoughts about the abuse
- **I - In vivo exposure**—Gradual exposure to trauma reminders in the child's environment (for example, basement, darkness, school), so the child learns to control his or her own emotional reactions
- **C - Conjoint parent/child sessions**—Family work to enhance communication and create opportunities for therapeutic discussion regarding the abuse and for the child to share his/her trauma narrative
- **E - Enhancing personal safety and future growth**—Education and training on personal safety skills, interpersonal relationships, and healthy sexuality and encouragement in the use of new skills in managing future stressors and trauma reminders

Target Population

TF-CBT is appropriate for use with sexually abused children or children exposed to trauma ages 3 to 18 and parents or caregivers who did not participate in the abuse.

Appropriate Populations for Use of TF-CBT

Appropriate candidates for this program include:

- Children and adolescents with a history of sexual abuse and/or exposure to trauma who:
  - Experience PTSD
  - Show elevated levels of depression, anxiety, shame, or other dysfunctional abuse-related feelings, thoughts, or developing beliefs
  - Demonstrate behavioral problems, including age-inappropriate sexual behaviors

- Children and adolescents who have been exposed to other childhood traumas (e.g., exposure to community violence, traumatic loss of a loved one) and show symptoms of depression, anxiety, or PTSD
- Nonoffending parents (or caregivers)

Meaningful assessment is important in selecting which children may benefit from TF-CBT and to inform the focus of the intervention. The assessment should specifically address PTSD, depressive and anxiety symptoms, and sexually inappropriate behaviors and other behavior problems, as these have been found to be most responsive to TF-CBT in multiple studies.

Limitations for Use of TF-CBT

TF-CBT may not be appropriate or may need to be modified for:

- Children and adolescents whose primary problems include serious conduct problems or other significant behavioral problems that existed prior to the trauma and who may respond better to an approach that focuses on overcoming these problems first.
- Children who are acutely suicidal or who actively abuse substances. The gradual exposure component of TF-CBT may temporarily worsen symptoms. However, other components of TF-CBT have been used successfully to address these problems. It may be that, for these children, the pace or order of TF-CBT interventions needs to be modified (as has been done in the Seeking Safety model; Najavits, 2002), rather than that TF-CBT is contraindicated for these populations.
- Adolescents who have a history of running away, serious cutting behaviors, or engaging in other parasuicidal behavior. For these teens, a stabilizing therapy approach such as dialectical behavior therapy (Miller, Rathus, & Linehan, 2007) may be useful prior to integrating TF-CBT into treatment.

Effectiveness of TF-CBT

The effectiveness of TF-CBT is supported by outcome studies and recognized on inventories of model and promising treatment programs.

Demonstrated Effectiveness in Outcome Studies

To date, at least 11 empirical investigations have been conducted evaluating the impact of TF-CBT on children who have been victims of sexual abuse or other traumas (see Empirical Studies at end of paper). In addition, there have been studies specifically showing the effectiveness of TF-CBT with children exposed to domestic violence (Cohen, Mannarino, & Iyengar, 2011; Weiner, Schneider, & Lyons, 2009). The findings consistently demonstrate TF-CBT to be useful in reducing symptoms of PTSD as well as symptoms of depression and behavioral difficulties in children who have experienced sexual abuse and other traumas. In randomized clinical trials comparing TF-CBT to other tested models and services as usual (such as supportive therapy, nondirective play therapy, child-centered therapy), TF-CBT resulted in significantly greater gains in fewer clinical sessions. Follow-up studies (up to 2 years following the conclusion of therapy) have shown that these gains are sustained over time.

Children showing improvement typically:

- Experience significantly fewer intrusive thoughts and avoidance behaviors
- Are able to cope with reminders and associated emotions
- Show reductions in depression, anxiety, disassociation, behavior problems, sexualized behavior, and trauma-related shame
- Demonstrate improved interpersonal trust and social competence
- Develop improved personal safety skills
- Become better prepared to cope with future trauma reminders (Cohen, Deblinger, Mannarino, & Steer, 2004)

Research also demonstrates a positive treatment response for parents (Cohen, Berliner, & Mannarino, 2000; Deblinger, Lippmann, & Steer, 1996). In TF-CBT studies, parents often report reductions in depression, emotional distress associated with the child's trauma, and PTSD symptoms. They also report an enhanced ability to support their children (Deblinger, Stauffer, & Steer, 2001; Cohen, Deblinger, et al., 2004; Mannarino, Cohen, Deblinger, Runyon, & Steer, in press).

Recognition as an Evidence-Based Practice

Based on systematic reviews of available research and evaluation studies, several groups of experts and Federal agencies have highlighted TF-CBT as a model program or promising treatment practice. This program is featured in the following sources:

- *Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices* (Chadwick Center, 2004) at http://www.chadwickcenter.org/kauffman/kauffman.htm
- The National Child Traumatic Stress Network's (2005) *Empirically Supported Treatments and Promising Practices,* supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), at http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices
- *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders et al., 2004) at http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf
- The California Evidence-Based Clearinghouse for Child Welfare (2011) at http://www.cebc4cw.org
- *SAMHSA Model Programs: National Registry of Evidence-Based Programs and Practices* at http://nrepp.samhsa.gov
- *Journal of Clinical Child and Adolescent Psychology* (Silverman et al., 2008).

What to Look for in a Therapist

Caseworkers should become knowledgeable about commonly used treatments before recommending a treatment provider to families. Parents or caregivers should receive as much information as possible about the treatment options available to them. If TF-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 TF-CBT model. If feasible, both the caseworker and the family should have an opportunity to interview potential TF-CBT therapists prior to beginning treatment.

Questions to Ask Treatment Providers

In addition to appropriate training and thorough knowledge of the TF-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 a TF-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 with whom they will work.

Some specific questions to ask regarding TF-CBT include:

- What is the nature of the therapist's TF-CBT training (when trained, by whom, length of training, access to follow-up consultation, etc.)? Is this person clinically supervised by (or did he or she participate in a peer supervision group for private practice therapists with) others who are TF-CBT trained?
- 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?
- What techniques will the therapist use to help the child manage his or her emotions and related behaviors?
- How and when will the therapist ask the child to describe the trauma?
- Will the therapist use a combination of individual and joint child-parent sessions?
- Is the practitioner sensitive to the cultural background of the child and family?
- Is there any potential for harm associated with treatment?

TF-CBT Training

TF-CBT training sessions are appropriate for therapists and clinical supervisors with a master's degree or higher in a mental health discipline, experience working with children and families, and knowledge of child sexual abuse dynamics and child protection. Therapists may benefit from sequential exposure to different types of training:

- Completing the 10-hour web-based training on TF-CBT on the Medical University of South Carolina website (http://tfcbt.musc.edu)
- Reading the program developer's treatment book(s) and related materials
- Participating in intensive skills-based training (2 days)
- Receiving ongoing expert consultation from trainers for 6 to 12 months
- Participating in advanced TF-CBT training for 1 to 2 days

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

Considerations for Child Welfare Agency Administrators

Agency administrators considering promoting the use of TF-CBT with children who have suffered trauma and their families will want to research several variables:

- Agency-level adjustments to support successful TF-CBT with families, such as modifications in policy, practice, and data collection
- Identification of therapists or mental health agencies with experience offering TF-CBT and who can work with children from child welfare populations (see above)
- Projected costs

When introducing TF-CBT as a referral option that child welfare workers may consider for children and families in their caseload, administrators will want to ensure that workers have a clear understanding of how TF-CBT works, the values that drive it, and its efficacy. Training for child welfare staff on the basics of TF-CBT, how to screen for trauma, and how to make appropriate referrals can expedite parent and child's access to effective treatment options (see the National Child Traumatic Stress Network's Child Welfare Trauma Training toolkit at http://www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008).

Research has shown that TF-CBT works best under the following organizational conditions:

- Organizational leadership that supports the use of evidence-based interventions, which, in turn, promote acceptance by workers and supervisors
- Provision of ongoing supervision to help child welfare workers make informed referrals to trauma-informed services and supervision for trained clinicians providing treatment

Conclusion

TF-CBT is an evidence-based treatment approach for children who have experienced sexual abuse, exposure to domestic violence, or similar traumas. Despite the impressive level of empirical support for TF-CBT and an established publication track record, many professionals remain unaware of its advantages, and many children and parents who could benefit do not receive such treatment. Further, in many communities around the nation, there may not yet be any TF-CBT trained therapists. The current demand for such evidence-based treatments, however, will encourage other professionals to acquire the needed training and to implement the TF-CBT model. Increased availability of TF-CBT, along with increased awareness among those making treatment referrals, can offer significant results in helping children to process their trauma and overcome emotional and behavioral problems following sexual abuse and other childhood traumas.

Resources for Further Information

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Online Resources

Center for Traumatic Stress in Children & Adolescents
http://www.pittsburghchildtrauma.net

Medical University of South Carolina
Guidelines for Treatment of Physical and Sexual Abuse of Children
http://academicdepartments.musc.edu/ncvc/resources_prof/OVC_guidelines04-26-04.pdf

Chadwick Center for Children and Families
Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices
http://www.chadwickcenter.org/Kauffman/kauffman.htm

National Child Traumatic Stress Network
Empirically Supported Treatments and Promising Practices
http://www.nctsn.org/resources/topics/treatments-that-work/promising-practices

University of Medicine & Dentistry of New Jersey, School of Osteopathic Medicine
CARES Institute
http://www.caresinstitute.org

SAMHSA Model Programs
National Registry of Evidence-Based Programs and Practices
http://nrepp.samhsa.gov

The California Evidence-Based Clearinghouse for Child Welfare
http://www.cebc4cw.org/program/trauma-focused-cognitive-behavioral-therapy

Interventions Addressing Child Exposure to Trauma: Part 1 – Child Maltreatment and Family Violence Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?mode=&pageaction=displayproduct&productid=846

Blueprints for Violence Prevention
University of Colorado Boulder's Center for the Study and Prevention of Violence
http://www.colorado.edu/cspv/blueprints

Training and Consultation Resources

Web-Based Training

Medical University of South Carolina (MUSC). Distance learning course on TF-CBT
http://tfcbt.musc.edu
Web-based training in TF-CBT is available as an adjunct or precursor to attending training workshops. The website training may be accessed free of charge. Therapists typically benefit from a 2-day intensive initial training course, as well as advanced training seminars after some experience implementing the model. Access to written resources such as books and treatment manuals (listed below), ongoing consultation or clinical mentoring, and regular clinical supervision are important complements to any web-based training.

Medical University of South Carolina (MUSC). Distance Learning course on Child Traumatic Grief
http://ctg.musc.edu
Web-based training is available on the application of TF-CBT principles and interventions to child traumatic grief along with presentation of grief-related interventions.

National Child Traumatic Stress Network. Child Welfare Trauma Training Toolkit
http://www.nctsn.org/products/child-welfare-trauma-training-toolkit-2008
This course is designed to teach basic knowledge, skills, and values about working with children in the child welfare system who have experienced traumatic stress. It also teaches how to use this knowledge to support children's safety, permanency, and well-being through case analysis and corresponding interventions tailored for them and their biological and resource families.

Web-Based Consultation

Medical University of South Carolina (MUSC). Distance Learning Consultation on TF-CBT
http://etl2.library.musc.edu/tf-cbt-consult/index.php
This web-based consultation tool provides information about frequently asked questions by providers implementing TF-CBT.

Implementation Guide

Child Sexual Abuse Task Force and Research & Practice Core, National Child Traumatic Stress Network. (2008). *How to implement trauma-focused cognitive behavioral therapy*.
http://www.nctsnet.org/nctsn_assets/pdfs/TF-CBT_Implementation_Manual.pdf

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Practitioner's Guides

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The following children's books by Stauffer & Deblinger also may be useful in teaching personal safety and other coping skills:

Stauffer, L. B., & Deblinger, E. (2003). *Let's talk about taking care of you: An educational book about body safety.* Hatfield, PA: Hope for Families, Inc.

Stauffer, L., & Deblinger, E. (2005). *Let's talk about coping and safety skills: A workbook about taking care of you.* Hatfield, PA: Hope for Families, Inc.

Acknowledgments:

The original (2007) and current versions of this issue brief were developed by Child Welfare Information Gateway, in partnership with the Chadwick Center for Children and Families at Rady Children's Hospital San Diego. Contributing Chadwick authors include Cambria Rose Walsh, Anthony P. Mannarino, and Charles Wilson.

The conclusions discussed here are solely the responsibility of the authors and do not represent the official views or policies of the funding agency. The Children's Bureau does not endorse any specific treatment or therapy.

Suggested Citation:

Child Welfare Information Gateway. (2012). *Trauma-focused cognitive behavioral therapy for children affected by sexual abuse or trauma.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Child Welfare Information Gateway

PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

ISSUE BRIEF

January 2013

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 effectivenss 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.

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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-NCTAbrochure.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.

Acknowledgment: This issue brief was developed by Child Welfare Information Gateway, in partnership with the Chadwick Center for Children and Families at Rady Children's Hospital-San Diego. Contributing authors include David Kolko, Ph.D, ABPP; Daniel Kleiner, Psy.D.; Barbara Baumann, Ph.D.; and Charles Wilson, M.S.S.W. This document is made possible by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The conclusions discussed here are solely the responsibility of the authors and do not represent the official views or policies of the funding agency. The Children's Bureau does not endorse any specific treatment or therapy.

Suggested Citation:

Child Welfare Information Gateway. (2013). *Alternatives for families: A cognitive-behavioral therapy (AF-CBT).* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.