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Application of Alternatives for Families: A Cognitive-Behavioral Therapy to School Settings

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Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT) is an evidence-based treatment for families with children aged 5 to 15 years who have been affected by verbal and physical aggression in the family. AF-CBT was designed to address risks for exposure to emotional and physical aggression as well as common clinical consequences of exposure to aggression by taking a family-systems approach to strengthening individual and family functioning. Given the target population, AF-CBT also integrates monitoring of and content related to family safety. This article provides an overview of AF-CBT including a discussion of appropriate populations and modalities, AF-CBT principles, and the theoretical basis of AF-CBT. The treatment is divided into three phases: (a) engagement and psychoeducation, (b) individual skill building, and (c) family applications and routines. The authors review each of these phases, the specific components and content of AF-CBT, and its empirical support. AF-CBT was one of the first treatments for physical aggression to be considered an evidence-based treatment. Information is provided on the opportunities and challenges of applying AF-CBT in schools, cultural considerations in AF-CBT's implementation, and how to obtain training in AF-CBT. Specifically, the authors provide details on the role of school psychologists in the delivery of AF-CBT, for example, as direct service providers or as important referral sources.
Alternatives for Families: Cognitive-Behavioral Therapy

OVERVIEW OF AF-CBT

Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT; Kolko, Herschell, Baumann, & Shaver, 2009; Kolko & Swenson, 2002) is an evidence-based treatment designed for families involved in the continuum of coercive behavior that includes broad forms of verbal and physical aggression. This continuum often includes family conflicts (arguments, hostility), the use of physical force for discipline and punishment, and acts involving caregiver-to-child aggression or child physical abuse. Because families with high conflict often include children who exhibit externalizing behavior problems, AF-CBT also has been applied to treat clinically significant behavior problems (e.g., oppositional defiant disorder, conduct disorder). More recently, AF-CBT has been shown to be effective with families without aggression, but with children exhibiting externalizing behavior problems (Dorn et al., 2009; Kolko, Campo, Kelleher, & Cheng, 2010).

The content and name of AF-CBT has evolved over the past three decades. The initial model was developed by David J. Kolko in the early 1980s in collaboration with Sharon (Fishman) Hicks and with consultation from David Wolfe, James Alexander, and Art Robin. After an outcome study in 1996 (Kolko, 1996a, 1996b), the approach was described as Abuse-Focused Cognitive Behavioral Therapy (V.1; Kolko, 1996a, 1996b, 2003a, 2003b). The name of AF-CBT was changed to Alternatives for Families: A Cognitive Behavioral Therapy in 2007 and adapted from 2007 through 2009 (V.2) by David J. Kolko, Amy D. Herschell, Barbara L. Baumann, and Meghan E. Shaver. The approach was renamed, in part, to more clearly reflect its focus on skills training designed to expand the family’s repertoire. Another reason for the change was related to the fact that the term abuse was later found to apply to only a minority of the families referred for AF-CBT and that, even when the term is applicable, the label may elicit stigma and obstruct rapport. A related model called the PARTNERS CBT for Physical Abuse was developed by Elissa J. Brown with consultation from Anne Marie Albano, Esther Deblinger, David J. Kolko, and Cynthia C. Swenson. Both of these interventions received federal support for their initial evaluation (National Center on Child Abuse and Neglect, National Institute of Mental Health, Substance Abuse and Mental Health Services Administration–National Child Traumatic Stress Network). Beginning in 2010, efforts were initiated to integrate these two sources. The authors also provide details on topics that psychologists and schools might want to consider in determining whether AF-CBT is a good fit for them and their setting.

KEYWORDS cognitive-behavioral therapy, physical aggression, verbal aggression, child physical abuse, psychotherapy
related approaches into the current version of AF-CBT (V.3) to enhance its scope, usefulness, and dissemination.

AF-CBT was designed to address key risks for and clinical consequences of family conflict (generally) and physical maltreatment of children (specifically). These risks include coercive parenting practices, anger hyperarousal, negative child attributions, and family conflict. The consequences include, but are not limited to, child aggression, poor interpersonal skills/functioning, and emotional distress. Thus, the intervention incorporates methods designed to address specific child, caregiver, and family adjustment problems commonly documented among such families in the research literature (Stith et al., 2009). For example, AF-CBT addresses common clinical consequences observed in children exposed to aggression including externalizing behavior problems (e.g., aggression), poor social competence, emotional dysregulation, and difficulties with relationships by including treatment topics such as emotion (anger and anxiety) regulation, social skills training, and behavior management. Common challenges experienced by caregivers, such as coercive parenting practices, anger, hyperarousal, and negative child attributions, are addressed by topics on behavior management, emotion regulation, and cognitive restructuring. Family conflict is addressed by problem solving and communication training. Given the target population, AF-CBT also attempts to address safety concerns by integrating safety work within training on general psychological skills (e.g., emotion regulation, problem solving, communication) as well as developing skills and plans that are more specific to exposure to abusive or traumatic experiences (e.g., safety planning, psychoeducation about physical force, disclosure, clarification, traumatic exposure).

AF-CBT treatment duration varies by severity, scope of problems, frequency of sessions, and level of family motivation. Some families may finish in 3 to 4 months; others may require up to 9 or 12 months. Treatment settings have included outpatient mental health clinics, schools, homes, residential treatment facilities, partial programs, and other treatment centers. Schools have served as an important setting for AF-CBT, which will be discussed later in greater detail. In some schools, psychologists have provided AF-CBT similarly to the traditional outpatient model. In other schools, psychologists have tailored the model to meet the needs of their settings and population by providing AF-CBT as a universal or more targeted group intervention. And in yet other schools, psychologists have not been able to provide the full model, and have instead served an important function of referring families to other service providers who can provide AF-CBT. Across settings, referral sources have included child protective services, mental health agencies, schools, child advocacy centers, family support centers, pediatrics, and self-referrals. The treatment modalities include individual caregiver, individual child, and joint caregiver–child or family sessions.
Appropriate Populations and Alternative Treatments

AF-CBT is most suitable for caregivers who may resort to uncomfortable or unsafe levels of aggression (e.g., excessive punishment, verbal attacks) and their school-aged children (age 5 through 15 years) who may exhibit behavioral or emotional problems. Left untreated, the consequences of these experiences likely will place children at risk for revictimization and may persist through adolescence and adulthood. There is a rich empirical literature documenting the negative effects of child physical abuse and high levels of family conflict on children (Kessler et al., 2005; Luntz & Widom, 1994; McCord, 1983; Pollock, Briere, Knop, Mednick, & Goodwin, 1990; Widom, 1989). AF-CBT seeks to reduce aggression and risk factors for aggression in order to ameliorate the consequences of these experiences for children and to attenuate the escalation of aggression.

Other interventions have been developed for children with similar, but distinct, histories and types of psychopathology. Trauma-focused cognitive behavioral therapy (Cohen, Mannarino, & Deblinger, 2006), a treatment developed for symptoms of posttraumatic stress disorder, would likely be more appropriate for children who have experienced sexual abuse or traumatic grief and their nonoffending caregivers. Parent-Child Interaction Therapy (Funderburk & Eyberg, 2011; Herschell, Calzada, Eyberg, & McNeil, 2002; McNeil & Hembree-Kigin, 2011), a treatment developed for externalizing behavior problems, would likely be more appropriate for preschool children (2 to 7 years of age) who have experienced child physical abuse and/or family conflict. Child Parent Psychotherapy (Lieberman, Ippen, & Van Horn, 2006), a treatment developed for trauma, may be more appropriate for young children (aged birth to 5 years) if they have experienced at least one traumatic event (e.g., witnessed domestic violence, experienced the death of someone close). It is also important to carefully determine whether caregivers or children with very low intellectual functioning or significant, uncontrolled psychopathology (e.g., active substance abuse, schizophrenia, major depression or bipolar disorder) may benefit from alternative or additional services rather than or in addition to AF-CBT.

AF-CBT Principles

In this section, we outline the key underpinnings of AF-CBT to highlight its guiding principles and philosophy.

Behavior, Rather Than a Diagnosis, Drives Treatment

As noted earlier, the primary foci of this intervention are risk factors and clinical consequences of physical and verbal aggression at the child, caregiver,
and family levels. At the child level, the target behaviors may be externalizing behavior problems, including aggression toward the caregiver or other family members, and general unmanageability. At the caregiver level, the target behaviors may be physical, emotional, or psychological aggression directed toward the child and other family members. At the family level, the target behaviors may be conflict, coercion, and hostility. In many cases, coercive behaviors are present at each level of a given family (child, caregiver, family), but this is not necessary for treatment to be applicable to the family. It is important to note, however, that some of the children or adolescents in these families have other comorbidities which are important to consider in applying AF-CBT. For example, AF-CBT includes methods to address child posttraumatic stress disorder and related anxiety, so the approach includes the flexibility to address the presence of these trauma-related emotional problems.

Specific treatment targets often include the following: child aggression, oppositionality, defiance, juvenile delinquency, and explosiveness; caregiver positive and negative parenting skills, and anger arousal (verbal and physical aggression); family conflict and cohesion; and barriers to treatment involvement. Secondary targets often include the following: child trauma, depression, anxiety, maladaptive attributions (e.g., self-blame), and social skills deficits; caregiver trauma, maladaptive attributions, inappropriate developmental expectations and views of child behavior; and readiness/willingness to change (e.g., engaged, skills learned; competencies attained at end of each phase of AF-CBT).

**STANDARDIZED ASSESSMENTS GUIDE TREATMENT**

Because the focus of AF-CBT is not a specific clinical disorder or problem (e.g., posttraumatic stress disorder, disruptive behavior disorder), it is important for treatment to be guided by an initial evaluation that assesses the severity of key treatment concerns or targets in the various domains addressed by AF-CBT. Accordingly, we have identified measures that can be efficiently administered to children and caregivers for this purpose (see Table 1, which was adapted from Kolko and Brown's [2011] Proposed AF-CBT Assessment and Outcome Measures for the 2011–2012 National Child Traumatic Stress Network’s Learning Collaborative in AF-CBT). Some of the more comprehensive measures that capture child externalizing behavior (e.g., oppositional defiant disorder/conduct disorder, aggression) and that do not need to be purchased through a publisher include the Strengths and Difficulties Questionnaire and the Vanderbilt ADHD Diagnostic Parent Rating Scale. Some of the most comprehensive measures that capture caregiver behavior that do need to be purchased or entail copyright restriction include the Alabama Parenting Questionnaire (parent report) and the Parent Perception
<table>
<thead>
<tr>
<th>Name and acronym</th>
<th>Citation</th>
<th>Topic and focus</th>
<th>Source</th>
<th>Scale</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Environment Scale (FES)</td>
<td>Moos, R. H., &amp; Moos, B. S. (1994). <em>Family Environment Scale Manual: Development, applications, research</em> (3rd ed.). Palo Alto, CA: Consulting Psychologist Press.</td>
<td>The scales measure people’s perceptions of their actual family, the individuals’ perceptions of their ideal family, and what they expect a family environment will be like under, for example, anticipated family changes. The measures include assessments of cohesion, expressiveness, and conflict, as well as control.</td>
<td>Parent and child</td>
<td>90 items</td>
<td>Cohesion Conflict</td>
</tr>
<tr>
<td>Alabama Parenting Questionnaire (APQ)</td>
<td>Frick, J. (1991). <em>The Alabama Parenting Questionnaire</em>. Unpublished instrument, University of Alabama</td>
<td>The 42-item scale was created around its five supported factors: positive parenting, inconsistent discipline, poor supervision, corporal punishment, and involvement. Although it is not a scale, there are a few questions regarding other discipline that provides information on an item by item basis.</td>
<td>Parent</td>
<td>42 items</td>
<td>Parental supervision Positive parenting Inconsistent punishment Corporal punishment Involvement Other discipline</td>
</tr>
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(Continued on next page)
<table>
<thead>
<tr>
<th>Name and acronym</th>
<th>Citation</th>
<th>Topic and focus</th>
<th>Source</th>
<th>Scale</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent Perception Inventory (PPI)</td>
<td>Hazzard, A., &amp; Christensen, A. (n.d.). <em>Parent Perception Inventory</em>. Department of Psychology, University of California, Los Angeles.</td>
<td>The scale was designed to determine the outcome of family therapy, focusing on behaviorally oriented outcomes. The Parent Perception Inventory focuses on children’s views of parent behaviors that need to be modified and their view of parent change after an intervention program.</td>
<td>Child</td>
<td>18 items</td>
<td>Positive behavior, Negative behavior, Negative subscore, Total score</td>
</tr>
<tr>
<td>Parenting Stress Index (PSI)</td>
<td>Abidin, R. R. (1997). <em>Parenting Stress Index: A measure of the parent–child system</em>. In C. P. Zalaquett &amp; R. J. Wood (Eds.), <em>Evaluating stress: A book of resources</em> (pp. 277–291). Lanham, MD: Scarecrow Press.</td>
<td>The Parenting Stress Index identifies dysfunctional parenting and predicts the potential for parental behavior problems and child adjustment difficulties within the family system. Although its primary focus is on the preschool child, the index can be used with parents whose children are 12 years of age or younger.</td>
<td>Parent</td>
<td>PSI: 120 items</td>
<td>PSI: Difficult child, Defensive responding</td>
</tr>
<tr>
<td>Parenting Stress Index Short Form (PSISF)</td>
<td></td>
<td></td>
<td>Parent</td>
<td>PSISF: 36 items</td>
<td>Parent–child Dysfunctional interaction, Parental distress, Parent distress, Parent–child dysfunction, Difficult child behavior</td>
</tr>
</tbody>
</table>

*Note.* SAB = scale of available behaviors; APP = child’s subjective appraisals of family, teacher and peer support; NET = size of child’s support network.
Inventory (child report), because both have positive and negative behavior items. We also encourage the use of the family conflict subscale from the Family Environment Scale or the family support subscale from the Survey of Children’s Social Support. Our Safety Check, previously named the Weekly Report of Discipline Practices, is useful for ongoing monitoring of caregiver anger and use of physical force. The Weekly Report of Discipline Practices was recently renamed to be more consistent with its function of monitoring concerns about the use of verbal and physical aggression in the home and the possible need to address threats to children’s safety. In addition, it is important to note that there is considerable assessment using functional analysis during the course of treatment, which may certainly supplement the findings obtained from an intake evaluation.

Family safety also is monitored and assessed on an ongoing basis. Not every family who participates in AF-CBT is at risk for physical aggression or abuse that may result in harm or injury to a child or other family member. However, this concern is still relevant in many cases participating in treatment, which raises the possibility that a family interaction may become dangerous and serve as a threat to a family member’s welfare. Therefore, AF-CBT includes recommendations for paying careful attention to any threats to the family’s safety and developing safety plans designed to reduce those threats. Accordingly, we incorporate a review of the caregiver’s level of anger towards children and use of force at the beginning of each session. In addition, suspicion or reports of the use of physical force merit check-ins that may require immediate discussions about the severity and effect of these incidents and possibly linkages of the family to crisis or child protective services.

Similarly, it is important to be mindful of a child’s increased trauma exposure or clinical deterioration during the course of therapy, which may require more immediate treatment plans that can keep the child safe and minimize further traumatic exposure. Although therapists using AF-CBT may not have the authority to institute such changes per se, they can provide important justification and details that can support these decisions by case-workers or other mental health professionals.

CASE CONCEPTUALIZATION FACILITATES SELECTION AND APPLICATION OF RELEVANT TREATMENT CONTENT

The topics within AF-CBT are meant to be delivered flexibly on the basis of the family’s progress and the results of regular assessment. This flexibility means that specific content modules or topics (e.g., behavior management, emotion regulation) may be tailored, abbreviated, repeated, or reordered within a treatment phase. Therapists are encouraged to select and apply AF-CBT content on the basis of their clinical judgment; conceptualization of the
TABLE 2 Phases and Key Procedures in Alternatives for Families: A Cognitive-Behavioral Therapy

<table>
<thead>
<tr>
<th>Phase</th>
<th>Key procedure</th>
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<tbody>
<tr>
<td>1. Engagement and psychoeducation</td>
<td>• Orientation to treatment</td>
</tr>
<tr>
<td></td>
<td>• Parental engagement and safety planning</td>
</tr>
<tr>
<td></td>
<td>• Psychoeducation about and monitoring of force/discipline</td>
</tr>
<tr>
<td></td>
<td>• Child discussion/disclosure of positive/negative experiences</td>
</tr>
<tr>
<td></td>
<td>• Consideration of clarification/preparation</td>
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<tr>
<td>2. Individual skill building (skills training)</td>
<td>• Cognitive processing and coping</td>
</tr>
<tr>
<td></td>
<td>• Emotion regulation: controlling your anger and anxiety</td>
</tr>
<tr>
<td></td>
<td>• Assertion/social skills/support plans</td>
</tr>
<tr>
<td></td>
<td>• Behavior management: promoting positive behavior and managing misbehavior (discipline)</td>
</tr>
<tr>
<td>3. Family applications and routines</td>
<td>• Clarification process</td>
</tr>
<tr>
<td></td>
<td>• Communication skills</td>
</tr>
<tr>
<td></td>
<td>• Problem-solving skills</td>
</tr>
<tr>
<td></td>
<td>• Developing family routines</td>
</tr>
</tbody>
</table>

family’s treatment needs, progress, and plan; and data obtained from regular assessments.

TREATMENT CONTENT IS BASED ON SEVERAL SKILLS-TRAINING CONTENT MODULES OR TOPICS

AF-CBT incorporates several content modules designed to initiate, support, and enhance the treatment of families involved in coercion and physical force. As noted in Table 2, these modules reflect clinical content designed to facilitate engagement, motivation, and safety. Specific modules are included to cover topics such as psychoeducation, key behavioral and cognitive-behavioral principles to enhance self-control, adaptive coping, behavior management, abuse and trauma exposure, as well as family clarification, communication, and problem solving. The content and methods found in AF-CBT clearly share similarities with many of the methods found in other evidence-based treatments in the child welfare and mental health fields (e.g., emotion regulation), but there is also unique content in AF-CBT (e.g., clarification between the perpetrator of physical aggression and his or her victim) and adaptations of the content to different targets (e.g., externalizing behavior).

TREATMENT PROCESS PROMOTES COMPETENCY-BASED PERFORMANCE

The focus on core components and clinical skills that unfold in sequential fashion places a premium on the mastery of previously reviewed material
before new material is introduced. This is one of the reasons why our therapist session guide emphasizes topics rather than sessions. We recognize that some topics may require several sessions or visits before the material is learned well enough for application. However, it seems important for fundamental skills to be acquired before new ones are learned. Within each topic, a careful process typically is followed to teach new skills. The process requires that the therapist (a) introduce the skill by providing a rationale and detailed explanation of its use, (b) model the skill, (c) encourage the client’s active demonstration of the skill, (d) provide feedback to the client on his or her skill use, (e) continue in session practice of the skill until the client reaches skill mastery, and (f) assign a home practice of the skill to help the client generalize the skill.

Theoretical or Clinical Basis of AF-CBT

AF-CBT incorporates behavioral and cognitive-behavioral methods that have been examined for use with physically abusive and at-risk families in several studies over the past four decades (Kolko, 1996b; Kolko et al., in press; Runyon, Deblinger, Ryan, & Thakkar-Kolar, 2004). To address individual- and family-level problems, AF-CBT draws from several conceptual models, including behavioral (e.g., coercion theory), learning (e.g., functional analysis, behavioral principles, social learning theory), cognitive (cognitive restructuring, misattributions/distortions), and family systems (e.g., reframing, functional skills) theories/therapies; developmental victimology (i.e., correlates of trauma exposure and trauma-related sequelae); and the psychology of aggression (e.g., psychoeducation, managing hostile reactions). AF-CBT emphasizes training in intrapersonal and interpersonal skills designed to enhance self-control, promote positive family relations, and reduce violent behavior. Common treatment targets include the following: caregiver self-control and use of positive discipline strategies, child coping and social skills, and family problem-solving routines. The treatment procedures are organized in three consecutive, interrelated phases that focus on engagement, individual skill building, and family applications. Each of these phases is subsequently discussed and shown in Table 2.

Phases and Components of AF-CBT

AF-CBT allows treatment to be tailored to individual family needs within a three-phase structure. Each phase is comprised of several topics. The topics can be flexibly delivered (adapted, abbreviated, or repeated) on the basis of the family’s progress as well as their treatment needs and goals within each phase. The expectation is that competencies will be reached within each phase before moving to the next phase.
Phase I, Engagement and Psychoeducation, focuses on assessing the family’s needs, enhancing participant motivation, and providing families with information. Therapeutic activities within this phase include discussing the referral incidents, learning about the CBT model, caregivers’ processing of their own experience of being parented, children learning affect identification, and encouraging a commitment to using a more positive behavioral repertoire and fewer negative behaviors within the family, including fewer words or actions that hurt (e.g., criticism, physical force).

Phase II, Individual Skill-Building and Processing of Abuse/Conflict, teaches children and caregivers affect regulation skills for anger and anxiety management, uses cognitive restructuring to address child and caregiver attributions related to the abuse and views regarding physical force (e.g., self-blame, beliefs in the effectiveness of physical punishment), teaches caregivers alternative parenting strategies to using hostile, coercive, and physical punishment, and teaches children interpersonal skills to enhance social adjustment and social support. In addition to building skills, children and their caregivers work with their therapist to begin to process the abuse and aggression. Children participate in a processing of their exposure to violence with the therapist using imaginal exposure and cognitive restructuring. What is sought is the development of a meaning making statement about the causes and effects of abuse. Caregivers work with the therapist to draft a clarification letter, in which they acknowledge the abuse and their role in it, apologize, and describe how they will keep their children safe going forward (including changes in their parenting strategies). Emotion regulation content includes some of the more common self-management procedures, but it focuses on anxiety and anger or hostility in caregivers and children. Psychoeducation also is included in several content areas related to mandated reporting, the role of child protective services, and the effect of verbal and physical aggression.

Phase III, Family Applications, includes the active participation of the caregiver–child dyads in communication training, the clarification session (in which the clarification letter is shared with the child and, if appropriate, children read their meaning making statement), family problem solving, relapse prevention (e.g., ensuring that effective family routines/behavior management are in place), and developing any needed aftercare plans.

Empirical Support for AF-CBT

AF-CBT was one of the earliest evidence-based treatments found to be efficacious for child physical abuse (Chadwick Center for Children and Families, 2004; Saunders, Berliner, & Hanson, 2003). As previously mentioned, the initial models for this intervention were developed in 1983 by the second author (D.J.K.) and a social worker (Sharon Fishman Hicks). This initial
application was to the families of young children on an inpatient unit who were referred for severe behavioral dysfunction and who were found to have significant histories of physical and verbal abuse that were not identified upon intake. The first model, cognitive-behavioral therapy (CBT), was directed to children and their caregivers in parallel groups for purposes of efficiency. The second model, family-systems therapy, was directed to each individual family. Both models were piloted separately with two groups of 12 families during the child’s inpatient stay and were associated with encouraging outcomes, including parental satisfaction, improved child behavior, and successful reintegration into the home or family reunification. These models were then translated into formal treatment protocols and evaluated in the first randomized clinical trial for this population that included cognitive-behavioral therapy and family-systems interventions involving children and caregivers as key participants as an outpatient treatment model (Kolko, 1996a, 1996b). This initial trial documented the efficacy of individual CBT and family-systems therapy, and showed that CBT reduced caregiver anger and physical force faster than family-systems therapy on parent- and child-reported anger and family problem ratings completed at the start of each session (Kolko, 1996a, 1996b). Other empirical studies documented the contribution of caregiver cognition and affect to child-directed aggression (Mammen, Kolko, & Pilkonis, 2002, 2003). Within this early application, the treatment model was described as abuse-focused CBT (Kolko, 1996b, 2003a, 2003b; version 1.0).

Since this early trial, the content from the CBT and family-systems therapy models was integrated to create version 2.0 (Kolko & Swenson, 2002). This material was adapted by community practitioners to establish its clinical and cultural appropriateness (Baumann & Kolko, 2003; Baumann, Kolko, Jones, Sturdivant, & Smith, 2006) and organized into a session guide with handouts. The intervention was also renamed Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT), to more accurately reflect the population to which it was being applied, which included cases other than those referred for abuse, and to reduce stigma and engagement challenges. The AF-CBT session guide was updated for ongoing national trainings and then further modified for use in a local community dissemination trial (Kolko, Herschell, Baumann, & Shaver, 2008; versions 2.1–2.3), which lead to the current manual (version 2.4; 8–1-2009; Kolko, Herschell, et al., 2009).

A recent program evaluation study documented the long-term sustainability and clinical effect of the early version of the integrated AF-CBT model (version 2.0) that was conducted five years after an initial training in 2002 (Kolko, Iselin, & Gully, 2011). The primary content modules in AF-CBT have also found to be efficacious when adapted for use with clinically referred children with behavior disorders in two recent clinical trials (Kolko, Campo, Kelleher, & Cheng, 2010; Kolko, Dorn, et al., 2009). In comparison with usual care, families receiving AF-CBT for behavior disorders in primary care
settings were significantly more likely to complete mental health services, report fewer barriers to treatment participation, report higher satisfaction with treatment, and show slightly better treatment outcomes (Kolko, Campo, Kelleher, & Cheng, 2010). Similarly, depending on the setting where treatment was delivered 36% (community) to 47% (clinic) no longer met criteria for a behavior disorder (oppositional defiant disorder or conduct disorder) and 48% (community) to 57% (clinic) of youth remained in the normal range for parent-rated externalizing behavior for as long as three years after treatment was completed (Kolko et al., 2009).

On the basis of systematic reviews of available research and evaluation studies, several groups of independent experts and federal agencies have highlighted AF-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; http://www.chadwickcenter.org/kaufman.htm)
- **Child Physical and Sexual Abuse: Guidelines for Treatment** (Sauders, Berliner, & Hanson, Eds., National Crime Victims Research and Treatment Center and The Center for Sexual Assault and Traumatic Stress; Office for Victims of Crime, U.S. Department of Justice, 2004; http://www.musc.edu/cvc/guidelinesfinal.pdf)
- **The National Child Traumatic Stress Network (Empirically Supported Treatments and Promising Practices** (Substance Abuse and Mental Health Services Administration, 2005; http://www.nctsn.org)
- **California Evidence Based Clearinghouse for Child Welfare** (Charles Wilson) (2008). (California Department of Social Services). Interactive database that informs the child welfare community about the research evidence for programs being used or marketed in California (http://www.cebc4cw/prg)
- **U.S. Attorney General’s Call to Action on Reducing Childhood Violence** (Gewirtz; Office of Juvenile Justice and Delinquency Prevention—Safe Start Center). Interactive database of evidence-based programs that reduce and ameliorate the effects of violence on children. (under development).

More recently, attention has focused on evaluating and disseminating AF-CBT in community agencies serving the child welfare, education and mental health systems. In the Partnerships for Families Study, we are evaluating a brief training program for AF-CBT as well as the effectiveness of AF-CBT within 10 community agencies in two Pennsylvania counties in an clinical trial funded by the National Institute of Mental Health1. Half of the

1 R01 MH074737; Treatment of Child Physical Abuse: An Effectiveness Trial; Principal Investigator: David Kolko; www.partnershipsforfamilies.org
182 participating practitioners were randomized to receive AF-CBT training and half received the usual training provided by their program. Of those randomized to receive the AF-CBT training, 89% participated in at least one training workshop or consultation and 68% completed a majority of the training activities. Practitioners who received the AF-CBT training reported greater CBT-related knowledge and use of specific AF-CBT teaching processes and abuse specific skills, as well as general skills at follow up than those who did not receive the AF-CBT training (Kolko et al., in press). Essentially, this current line of research is focused on understanding the most effective methods for training therapists in AF-CBT and for applying it to community settings.

Application of AF-CBT in Schools

OPPORTUNITIES IN SCHOOL SETTINGS

Although AF-CBT was designed for typical outpatient mental health settings, schools afford many opportunities for families and therapists. Only 25% of children in the child welfare system who have mental health needs receive services (Burns et al., 2004). Family members, especially fathers and ethnic minority members, are often reluctant to bring children to mental health centers because of issues of stigma, misinformation, or lack of access (Bradby et al., 2007; Thurston & Phares, 2008). In addition, even after appointments are scheduled, caregivers often fail to attend outpatient therapy sessions (Doherty & McCarthy, 2010; Lefforge, Donohue, & Strada, 2007). A substantial amount of mental health services takes place within families' homes, particularly for families involved in the child welfare system. AF-CBT emphasizes working with children and caregivers, individually and together. Often it is difficult to work with family members individually in home settings because of privacy and safety concerns. Schools can provide an easily accessible, safe, nonstigmatizing location where families can receive information they need to make informed decisions about treatment for themselves and their children. This makes schools an ideal location for AF-CBT sessions for mental health and school personnel. AF-CBT also fits well in school settings given the target age range of 5 to 15 years for children.

Another benefit to providing AF-CBT services in schools is that it addresses key issues that inhibit learning in the classroom. Child maltreatment and posttraumatic stress disorder can result in neurobiological changes in children that affect learning and memory (Cohen, Perel, DeBellis, Friedman, & Putnam, 2002). In turn, children with behavior problems, such as oppositional defiant disorder, are at a higher risk for child maltreatment (Ford et al., 2000). By decreasing child externalizing behavior at home and in the classroom, and decreasing the risk for future child abuse through the implementation of AF-CBT, it seems plausible that we can prevent further
disruptions to the educational and family environment and damage to the child’s developing neurological system.

These potential benefits may be realized through individual sessions, as mentioned above, or possibly through groups. A major component of AF-CBT is the second phase which focuses on skill development (primarily emotion regulation, cognitive processing, and social skills). It is possible to modify this phase to develop skill groups for children. Brown, McQuaid, Farina, Ali, and Winnick-Gelles (2006) implemented a school-based, trauma-specific intervention program for inner-city children exposed to multiple trauma events (on average, six events). The universal intervention was a 10-session skill-based classroom intervention, including many of the skills mentioned previously. Although there was no control group to permit direct inferences about treatment effects, symptoms of posttraumatic stress disorder, depression, and anger decreased from pre- to postuniversal intervention. Following the classroom intervention, children who continued to meet criteria for posttraumatic stress disorder were offered an individualized intervention, including review of skills and imaginal exposure, which resulted in further improvements. The differential influence of the classroom and individual interventions suggest that each intervention may target a separate group of symptoms.

Schools also are ideally suited for peer group mentoring, which has great potential for children for building social skills and self-esteem (e.g., Karcher, 2009). Such groups, perhaps conducted by school psychologists, can take place during school hours, or before or after school. They can vary or be defined by age, gender, language, or cultural issues.

**CHALLENGES IN SCHOOL SETTINGS**

As with any intervention, there are challenges as well as opportunities. One of the challenges to using AF-CBT in schools is logistics. It can be difficult to arrange for trained staff to provide treatment at schools on consistent days and times, to find space within schools that is conducive to therapeutic work, and to maintain the confidentiality that is necessary for the sensitive topics involved with caregivers and children who are appropriate for AF-CBT. In addition, transportation can be difficult for families to obtain and may require extra efforts by school personnel to coordinate, especially for families with few resources or problem solving skills. These barriers to engagement and participation may need to be addressed at multiple levels within the educational system before contacting families for treatment. Although a perfect setting is not necessary for AF-CBT to be successful, coordination among professionals will set up families for success.

A major focus of AF-CBT is the family-system context in which coercion or aggression occurs; therefore, involving caregivers and families in sessions is a top priority, which can sometimes be difficult in a school setting. School
personnel may need to overcome parental reluctance to approach the school or become involved with mental health services generally. AF-CBT provides engagement tools specifically to address the pros and cons to participating in treatment. These can be used over the phone by school personnel if needed, to help caregivers appreciate the benefit of attending sessions at the school. Compounding this difficulty is that in a few extreme cases (not all AF-CBT cases), there may be legal issues that have to be considered (e.g., protection from abuse orders that require caregivers to remain separated).

School personnel also may be particularly sensitive to bringing a perpetrator and his or her victim together in treatment. This is often a concern in outpatient settings, but might be further heightened in a school setting. For example, in families where child physical abuse has occurred, we have found that those families are often reunited even in cases where children have sustained significant injuries. Given that the family will be together, it makes sense to include them all in treatment; however, bringing perpetrators and victims together can be controversial. In AF-CBT, individual work is done with caregivers and children. Once that work is successfully completed, family sessions take place including a clarification session in which the perpetrator takes responsibility for what has happened, apologizes, and explains to the child how things will be different in the future. It is unfortunate that no research to date has established how school professionals, such as school psychologists view these issues and their preparedness to undertake these tasks.

Cultural Considerations

AF-CBT has been used extensively with families representing diverse cultural backgrounds. Clients have varied by socioeconomic status, race, ethnicity, religion, and community (from inner-city to rural). The treatment is not designed for any one cultural group; the focus on engagement and retention techniques, including motivational interviewing, addresses many of the concrete and conceptual barriers experienced by physically abusive families of color (Berliner & Brown, 2010).

The initial engagement phase of AF-CBT includes references to learning about the family’s history and cultural background, including attention to cultural views about children, physical discipline, and other issues related to behavior management. An emphasis also is placed on learning about the caregivers’ history of being disciplined, perspectives on the use of violence, the role of violence in the media and family relationships, relevant religious beliefs about discipline, and community supports and resources. The PARTNERS Program, one of the two major sites of the development of AF-CBT, is dedicated to serving inner-city families of color. Using included engagement strategies, PARTNERS has increased the show rate for first visits from 50%
Alternatives for Families: Cognitive-Behavioral Therapy

At present, Dr. Brown and her PARTNERS team are conducting a Department of Justice-funded randomized clinical trial of the 2011 version of AF-CBT (Project CONNECT; Brown, PI). They are adapting AF-CBT to address the concrete and conceptual barriers to service access for the multicultural, economically disadvantaged community of Queens. Modifications will be made for (a) adolescents, (b) multiple forms of violence, and (c) Latino and African/Caribbean American families, including the translation of all materials into Spanish. AF-CBT materials also have been systematically reviewed in two funded projects designed to adapt materials for use with African American families and practitioners (Baumann & Kolko, 2003; Baumann, et al., 2006).

Training in AF-CBT

AF-CBT faculty are involved in conducting professional workshop trainings in AF-CBT on a local, national, and international basis. These trainings have provided useful feedback about how to consult with various practitioners to enhance their clinical competencies in this model. These collaborations and partnerships have allowed us to carefully examine, modify, and improve many of our treatment as well as training procedures and handouts.

Several training and implementation materials are available for AF-CBT, including informational brochures, an implementation guide, source book (Kolko & Swenson, 2002), a treatment session guide (Kolko, Herschell, et al., 2009), and handouts for families. AF-CBT also was recently featured in the Hope Video on Family Focused Interventions that is being distributed nationally by the National Child Traumatic Stress Network (http://www.nctsn.org).2 Also, on the basis of a recent national poll of NCTSN affiliates, the NCTSN has chosen AF-CBT as its featured evidence-based treatment for dissemination in a year-long national training program, a learning collaborative, for organizations that can commit to sending a team of several staff (e.g., several therapists, at least one supervisor, one senior administrator) to training. Across the United States, 14 sites are currently participating in this learning collaborative.

A typical AF-CBT training sequence begins with the completion of an agency or therapist training request and readiness assessment. After training dates are set, therapists are asked to review the source book, session guide, and treatment handouts before coming to training. In general, training consists of a 3-day intensive, experiential-based clinical training covering each

2 The video was created as part of a program funded by the Substance Abuse and Mental Health Services Administration and can be seen at http://www.afcbt.org/hopevideo.
of the three AF-CBT phases. Afterwards, therapists conduct AF-CBT with at least two pilot cases and receive ongoing case consultation from an AF-CBT trainer through conference calls every 3–4 weeks for 1 year. During that year, therapists participate in an advanced one-day training focused on case conceptualization and addressing particular issues or concerns that have arisen during the consultations. Therapists also are asked to participate in ongoing monitoring of treatment fidelity by submitting audiotapes or performance samples that are reviewed and rated by AF-CBT trainers.3

AF-CBT materials and content also are being disseminated at regional and national conferences devoted to enhancing the professional response to child abuse and neglect. These conferences have included, for example, those sponsored by the American Psychological Association; American Professional Society on the Abuse of Children; Office of Children, Youth, and Families at the Department of Health and Human Services; Society for Research in Child Development; Children’s Justice Institute Conference; and Hope and Healing Conference.

**Therapist Considerations**

Therapists who are best suited for training in AF-CBT are those with a Master’s degree or higher in a human services field such as school psychology or social work; have received training and supervision in CBT practices; and have knowledge of and experience with family aggression and child trauma. The AF-CBT model requires therapists to be comfortable with and be able to manage high levels of aggression and family conflict. The model is designed for therapists who can deliver all of the individual and family treatment content so some experience and flexibility is necessary in providing child, adult, and family sessions.

**School Considerations**

School systems best suited for training in AF-CBT are those with the ability to sustain the model in their schools, which requires accounting for the time it takes to fully train school personnel, managing staff turnover, and thinking creatively regarding engaging families and funders. AF-CBT requires an investment of time by therapists and administrators in order for the model to be successful. The intensive training required by therapists over the course of a year can disrupt regular productivity and scheduling regimens. School psychologists often serve multiple schools. It is important for them to be able to work with all administrators to carve out time for training workshops, consultations, child, caregiver, and family sessions. It can be difficult for staff

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3 Current information on training opportunities can be found at http://www.afcbt.org.
to compartmentalize AF-CBT practice to a particular school setting, and is disruptive to the training process.

Turnover among mental health personnel can be high. Some organizations have provided AF-CBT training to more therapists than initially expected to implement the model, to prevent disruptions to families in the case of staff turnover. Administrators, supervisors, and managers are also encouraged to attend AF-CBT trainings. This gives them the background they need to promote the model in grants and proposals, as well as to policy makers when explaining the need for quality services that address trauma and child maltreatment in school settings.

The training workshops and case consultations offered as part of the AF-CBT training process are tailored to the needs of the population identified by the participating organizations. Consideration is given to the language, cultural affiliation, immigration, and cultural histories of the families whom practitioners serve. Trainers and practitioners work together to share expertise and learn, when needed, additional information that will help families to succeed.

**SUMMARY AND CONCLUSIONS**

AF-CBT, an evidence-based treatment for families involved in coercive behavior that includes verbal and physical aggression, has been applied to school settings, where it is relevant, applicable, and needed. While AF-CBT’s emphasis on including all members of families who can sometimes be violent may pose some challenges within school settings (e.g., dealing with legal issues related to protection from abuse orders; managing high levels of hostility), the benefits are substantial. Research has demonstrated that AF-CBT can support families in decreasing child behavior problems, increasing caregiver skills, and reducing reabuse rates (e.g., Kolko 1996a, 1996b). Current research on and efforts within AF-CBT have been focused on establishing an evidence base for it implementation so that the treatment can be more available to therapists, including school psychologists, and the families with whom they treat.4

**REFERENCES**


4 Additional information on AF-CBT, including information on current training opportunities, can be found at http://www.afcbt.org.


