

APSAC Research-to-Practice Brief

Study Title: AF-CBT for Families Experiencing Physical Aggression or Abuse Served by the Mental Health or Child Welfare System: An Effectiveness Trial

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Introduction:

Although treatment studies have investigated the effect of programs to prevent child physical abuse, very few effectiveness studies have explored the effect of treatment in families who have experienced or are at risk of experiencing child physical abuse.

Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) has been found to improve child, caregiver, and family functioning compared to routine community services, but has not yet been studied in a larger effectiveness trial in a real-world community setting. In this study, community providers within child welfare and mental health systems were randomized to receive either six months of AF-CBT training or treatment as usual (TAU).

Research Questions/Hypotheses:

- (1) Compared to community providers providing treatment as usual (TAU), are providers trained in AF-CBT more likely to treat families who present with histories of physical force/aggression and more likely to directly target aggression during treatment?
- (2) Does AF-CBT show greater improvements than TAU on child, caregiver, and family functioning through a one-year follow-up period?
- (3) Is AF-CBT associated with a greater reduction in official reports of physical abuse compared to TAU?

Study Sample/Setting:

The sample for this study was 10 community agency programs in Pennsylvania contracted to provide services in either the mental health system (MHS) or the child welfare system (CWS). 182 providers were randomized to either the AF-CBT condition or treatment as usual (TAU). Providers randomized into the AF-CBT condition received six months of AF-CBT training and began approaching families regarding study participation following the training. Families receiving services at these agencies were invited to participate in the study if they had a child 5-15 years of age, had weekly child contact, and reported at least

one behavior related to physical force in the past 12 months. Families were excluded from the study if an adult had severe mental illness, substance abuse, or intellectual limitations. Enrolled families totaled 195 (AF-CBT = 122, TAU = 73). Provider outcome measures included rate of AF-CBT with families, and number and nature of treatment goals attained. Child outcome measures included overall dysfunction, minor assault, and posttraumatic stress. Caregiver outcome measures included positive parenting practices, anger and threats of physical force, physical abuse risk, and minor assault. Additional outcome measures included family dysfunction, family conflict, and official CWS reports of physical and emotional abuse.

Findings:

AF-CBT showed many benefits over TAU, though benefits differed by type of service agency.

Mental health system providers trained in AF-CBT provided more service to families with anger, aggression, and/or abuse during treatment and follow-up than TAU providers. In the child welfare system, AF-CBT providers provided more service than TAU providers only at six months. In the mental health system only, AF-CBT cases showed greater reduction than TAU cases in child problems, physical assault directed to caregivers, family conflict, and abuse risk score. In the child welfare setting only, AF-CBT providers addressed more threats of physical force during treatment than TAU providers. However, caregiver use of threats only decreased (at a trend level) in the mental health system. Accordingly, in the child welfare setting, families with AF-CBT providers achieved more of their overall treatment goals and aggression-specific goals at 12 months than families TAU providers. In both mental health and child welfare service systems, AF-CBT cases showed a greater reduction in family dysfunction than TAU cases. AF-CBT cases also showed a significant reduction in the number child physical and emotional abuse reports from baseline to 18 months after baseline, whereas TAU cases did not.

Recommendation:

Early evidence shows that families benefit from AF-CBT, and yet prior to this study, no large-scale effectiveness trial had been completed. Although it was necessary to randomize providers to different training conditions for this study, training many providers at the agency or community level is likely more sustainable over time. Existing strengths within systems and the providers who practice in those systems may influence outcomes. Mental health system providers had more educational training and job stability, whereas child welfare system providers had more experience with high risk families and more resources to support intensive interventions. Further research is needed to determine which agency

characteristics have the strongest association with outcomes, which will help agencies identify areas for improvement and close existing training gaps. Child welfare and mental health providers may help families access AF-CBT by sponsoring trainings for their own providers and by maintaining referral lists of local AF-CBT-trained professionals.

The results from this study indicate that both mental health and child welfare agencies were able to achieve benefits after a six-month training in AF-CBT, with more benefits evident in mental health settings. Given that the current training model for AF-CBT includes more extensive clinical training, supervision, and technological support than the six-month training implemented in this study, longer or more intensive training in AF-CBT may further strengthen outcomes. The authors suggest that training regarding tailoring goals and treatment strategies to each unique family may be particularly beneficial.

Bottom Line:

Many providers are reluctant to engage with families who exhibit a history or risk of physical abuse. AF-CBT training for providers is an effective way to increase service engagement with high risk families and also shows positive child, caregiver, and family outcomes. Further examination of agency characteristics, provider backgrounds, and family characteristics can deepen our understanding of how to effectively implement evidence-based treatments with high-risk families.

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About the Research-to-Practice Brief Author

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