



TREATMENT RESEARCH ON AF-CBT

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CHILD ABUSE/FAMILY CONFLICT – CHILD WELFARE

Kolko, D. J. (1996a). Individual cognitive-behavioral treatment and family therapy for physically abused children and their offending parents: A comparison of clinical outcomes. *Child Maltreatment, 1*, 322-342.

The individual child/parent cognitive behavioral therapy (CBT) and family therapy (FT) components that are now integrated in AF-CBT were originally evaluated separately and compared to a third condition consisting of routine community services (RCS) in an initial randomized clinical trial (N=55) that evaluated key outcomes through a one-year follow-up assessment. Some adaptations of treatment components were included in CBT (Behavior Therapy/social learning, Cognitive Therapy) and some in FT (Behavioral Family therapy). The sample consisted mainly of families referred by the child welfare system due to allegations of child physical abuse, but also included some families who were referred for physical discipline/punishment or who self referred for concerns about the use of physical force. Measures included the Child Behavior Checklist, Conflict Tactics Scales, Child Abuse Potential Inventory, the Family Environment Scale (cohesion, conflict), the general functioning scale of the Family Assessment Device, the Child Abuse Potential Inventory, the Parenting Scale, and the Beck Depression Inventory, among other exploratory measures.

In terms of the overall outcomes through follow-up among all three conditions, both the individual CBT and family therapy conditions reported greater improvements than RCS in terms of child measures reflected less child-to-parent aggression ($p = .006$) and less child externalizing behavior ($p = .002$); and there were fewer peer problems in FT ($p = .03$). CBT and FT also showed significant improvements in parent measures reflecting lower parent-to-child aggression ($p = .04$), child abuse potential scores ($p = .009$) and the proportion of cases falling below the clinical cutoff ($p = .03$), individual treatment targets reflecting reduced abusive behavior (p 's = .0001), fewer beliefs about the need for using corporal punishment ($p = .0001$), and both lower psychological distress ($p = .02$), and less drug use by final follow-up for CBT only ($p = .03$). In terms of family outcomes, results indicated less conflict reported by children for FT only ($p = .01$) and less conflict for both conditions reported by parents ($p = .04$), and more cohesion in CBT reported by children for both conditions ($p = .02$).

Official child welfare records were collected on each family for up to a one year follow-up period. These data revealed lower, albeit nonsignificant, rates of recidivism among the adults who participated in the individual CBT (5%) and family therapy (6%) conditions, compared to those in RCS (30%). Parallel rates of recidivism were found for the identified abused children in this study in the three conditions: CBT (10%), family therapy (12%), and routine services (30%).

There were few differences between individual CBT and family therapy. Further, these outcomes were not influenced by child age, gender, ethnicity, parent education, one-parent vs. two-parent household, SES, or the levels of child behavior problems, parental distress, and family violence. Both CBT and family therapy were conducted with high fidelity, had high rates of session attendance, and had high consumer satisfaction ratings.

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

In this report, we compared the treatment course of the two randomized conditions (CBT vs. FT) from the original outcome study (see Kolko, 1996a) on weekly ratings of parents' use of physical discipline/force and anger problems collected during each treatment session from children and their parents/caregivers using items developed for this client population (the Weekly Report of Abuse Indicators, WRAI). Based on summaries of these reports across sessions, parental anger ratings were somewhat lower for CBT (vs. FT) based on child reports ($p = .07$) and were significantly lower for CBT on parent reports ($p = .05$). Further, lower family problems ratings were found for CBT based on child reports ($p = .05$). There was also a significant reduction in the use of physical force by the end of treatment for CBT as reported by children ($p = .007$) and parents ($p = .04$). Child reports showed that the time to the first use of force was much later for CBT parents (Mantel-Cox = 7.46, $p = .006$; Mean survival time = 120 vs. 61 days). Parent reports revealed a somewhat similar pattern for CBT and FI, but the overall difference was not statistically significant (Mean survival time = 105 vs. 48 days). The study provides empirical justification for monitoring and then addressing potential indicators of potential abusive behavior during treatment.

Mammen, O. K., Kolko, D. J., & Pilkonis, P.A. (2002). Negative affect and parental aggression in child physical abuse. *Child Abuse & Neglect*, 26, 407-424.

Parental negative affect is a risk factor for child physical abuse. As negative affect contributes to aggression, and because physical abuse involves an aggressive act directed at the child, we examined the relationship between negative affect and parent-to-child aggression (PTCA) in parents reported to Child Protective Services for physical abuse. Baseline assessment data were retrospectively examined on 49 participants in a treatment study for child physical abuse. The negative affects studied were depression, anxiety, and hostility on the Beck Depression Inventory and the Brief Symptom Inventory. PTCA was assessed using the physical aggression subscales (Minor and Severe Physical Violence) of the Conflict Tactics Scale. The contribution of these negative affects to PTCA was examined after controlling individually for the effects of parental attributions and contextual variables widely regarded as etiological factors in child physical abuse. Contributions of negative affect to PTCA after individually controlling for other predictors were found for Minor Physical Violence ($p = .08$), but not Severe Physical Violence. Findings were strongest with depression on the Beck Depression Inventory ($p = .002$) and to a lesser extent with hostility on the Brief Symptom Inventory ($p = .071$). Finding that negative affect contributed to PTCA in this sample suggests that it may be important to study the effects of emotion-focused treatments in physically abusive parents. These findings also suggest that PTCA may have qualities of impulsive aggression, a form of aggression that is conceptualized as driven by negative affect, occurs in response to aversive events, and is not planned.

Mammen, O.K., Kolko, D.J., and Pilkonis, P.A. (2003). Parental cognitions and satisfaction: relationship to aggressive parental behavior in child physical abuse. *Child Maltreatment*, 8, 288-301.

There are limited data on cognitions and satisfaction with the child in parents who have physically abused their children. Therefore, we examined convergence among these constructs, and their relationships to parental aggression among participants in a treatment study for child physical abuse. Data were examined at two time points 12 weeks apart. The cognitions (unrealistic expectations of the child, perception of lack of control, and hostile attribution bias) and satisfaction with the child showed little convergence. Only parental satisfaction correlated significantly with aggressive parental behavior directed at the child ($p = .01$), even after controlling for social desirability. Where there were significant correlations between externalizing child behavior and aggressive parental behavior and between parental depression and aggressive parental behavior ($p = .01$), some limited

support was found for an indirect path through parental satisfaction ($p = .10$). If replicated, these findings suggest it may be useful to focus on parental satisfaction in research on child physical abuse.

Kolko, D. J., Iselin, A. M., & Gully, K. (2011). Evaluation of the sustainability and clinical outcome of Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT) in a child protection center. Child Abuse & Neglect, 35, 105-116.

This paper describes the long-term sustainability and outcome of Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT) as delivered by practitioners in a community-based child protection program who had received training in the model several years earlier. Formerly described as Abuse-Focused CBT, AF-CBT is an evidence-based treatment (EBT) for child physical abuse and family aggression/conflict that was included in the National Child Traumatic Stress Network's initial EBT dissemination efforts in 2002. Seven practitioners received a day-long training workshop, 12 monthly case consultation calls, and a follow-up booster workshop. The program's routine evaluation system was used to document the clinical and treatment outcomes of 52 families presenting with a physically abused child who received AF-CBT content between two and five years after training had ended. Measures of the use of AF-CBT and four other EBTs documented their frequency, internal consistency, intercorrelations, and relationship to several therapist- and parent-rated outcomes.

The amount of AF-CBT General and Abuse-specific content delivered was found to predict several clinical and functional improvements in both children and caregivers, above and beyond the influence of the unique content of the other four EBTs. Greater use of AF-CBT General content tended to be associated with improvement in anger scores ($p = .06$). Greater AF-CBT Abuse-specific content was related to significant decreases on CBCL externalizing problems ($p = .03$), TSCC anxiety scores ($p = .008$), and TSCC anger scores ($p = .005$), and significant increases in social competence ($p = .01$) and reductions in aversive miscommunication on the SBI ($p = .05$). At discharge, greater AF-CBT general content was related to having a perceived better long-term prognosis and caregiver's reports of the helpfulness of the treatment for them as caregivers, whereas greater use of the Abuse-specific content was related to reductions in ratings of the child's being scared/sad ($p = .01$), being more safe from harm ($p = .04$), being better able to have friends without harming them ($p = .003$), having a positive prognosis ($p = .01$), being better able to have friends ($p = .02$), and being more likely to not to violate other's primacy ($p = .001$). Thus, the two AF-CBT content scores were differentially related to several of these outcomes. These novel naturalistic data document the sustainability and clinical benefits of AF-CBT in an existing community clinic serving physically abused children and their families, and are discussed in the context of key developments in the treatment model and dissemination literature.

Kolko, D. J., Baumann, B. L., Herschell, A. D., Hart, J. A., & Wisniewski, S. (2012). Implementation of AF-CBT by Community Practitioners Serving Mental Health and Child Welfare: A Randomized Trial. Child Maltreatment, 17, 32-46.

The Partnerships for Families (PFF) project is a randomized clinical trial designed to evaluate the dissemination of Alternatives for Families: A Cognitive-Behavioral Therapy (AF-CBT), an evidence based treatment for family conflict and coercion, including child physical abuse. To evaluate the effectiveness of a training program in this model, 182 community practitioners from 10 agencies were randomized to receive AF-CBT training ($n = 90$) using a learning community model (workshops, consultation visits) or training as usual (TAU; $n = 92$) which provided trainings per agency routine. Practitioners completed self-report measures at four time points (0, 6, 12, and 18 months following baseline).

Of those assigned to AF-CBT, 89% participated in at least one training activity and 68% met a "training completion" definition. A total of 80 (44%) practitioners were still active clinicians in the study by 18-month assessment in that

they had not met our staff turnover or study withdrawal criteria. Using an intent to train design, HLM analyses revealed significantly greater initial improvements for those in the AF-CBT training condition (vs. TAU condition) in CBT-related knowledge ($p = .001$) and use of AF-CBT teaching processes ($p = .001$), abuse-specific skills ($p = .05$), and general psychological skills ($p = .002$). In addition, practitioners in both groups reported significantly more negative perceptions of organizational climate through the intervention phase ($p = .01$). These findings are discussed in the context of treatment training, research, and work force issues as they relate to the diverse backgrounds, settings, and populations served by community practitioners.

Kolko, D. J., Fitzgerald, M. & Laubach, J. (2014). Evidence-Based Practices for Working with Physically Abusive Families: Alternatives for Families: A Cognitive Behavioral Therapy (pp. 59-66). In R. M. Reece, R. F. Hanson, & J. Sargent (Eds). Treatment of Child Abuse: Common Ground for Mental Health, Medical and Legal Practitioners (2nd ed.). Johns Hopkins University Press: Baltimore, MD.

This chapter seeks to provide the reader with an overview of *Alternatives for Families: A Cognitive Behavioral Therapy* (AF-CBT) by giving insights into the general nature of AF-CBT, its theoretical framework, target population, expected outcomes, empirical evidence, and advantages and disadvantages. The chapter also aims to highlight the unique disposition of AF-CBT to integrate several therapeutic methods. AF-CBT targets both verbal and physical aggression in families, which includes family conflict, caregiver or children coercion or aggression, or child physical abuse. To work with this broad target population, AF-CBT teaches diverse psychological skills to children, caregivers, and families to help them find alternatives to the use of explosive anger and aggression. 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, 2010; Runyon & Urquiza, 2012).

The implementation of several of these skills is explicitly coordinated to maximize the likelihood that they are used and encouraged by both children and caregivers. In addition, the integration of content domains and specific treatment components based on several conceptual models was designed to address the various clinical features of families involved in coercive behavior. There is emerging support that these treatment elements are associated with improvements in the well-being of the child and family, and in child safety and welfare, as prior findings suggest that family members report reductions in family conflict aggression and hostility, and a child's risk of harm. However encouraging, developments are needed that can enhance the efficiency with which AF-CBT is applied and expand its availability in order to ensure that the many practitioners who regularly serve these challenging families in diverse settings are supported during the course of routine practice.

Kolko, D. J., Simonich, H., & Loiterstein, A. (2014). Alternatives for Families: A Cognitive Behavioral Therapy. An Overview and a Case Example. In A. Urquiza & S. Timmer (Eds.), Evidence-Based Approaches for the Treatment of Maltreated Children (pp. 187-212). New York: Springer.

This chapter provides an overview and update on Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT; www.afcbt.org) an evidence-based intervention that has been adapted for family conflict and coercion, emotional and physical abuse, and child behavior problems (version 3.0, 11-1-2011). We review some of the conceptual underpinnings of this intervention model (Kolko & Swenson, 2002), the purpose for the intervention, common risks for and consequences of exposure to abusive or coercive behavior, characteristics of the population, and an update on research support for the model. The chapter includes a description of screening and assessment measures recommended for use in AF-CBT and the intervention protocol which consists of set of treatment methods that are organized in three phases (Engagement and Psychoeducation, Individual Skill-building, and

Family Applications) to address a range of clinical targets in individual or joint sessions (e.g., use of coercion, physical force, and aggression, anger, physical abuse or discipline related trauma symptoms, misattributions, poor social competence, safety planning and clarification, family communication and problem-solving). A recent case application with an 11-year old boy is presented to highlight the application of the protocol to these various clinical domains. The child and his father completed the Alabama Parenting Questionnaire and the child also completed the UCLA Reaction Index at intake and at the end of treatment. Both child and dad reported improvement on the APQ positive parenting (12 to 22; 13 to 20), parental involvement (21 to 25; 19 to 28), inconsistent discipline (18 to 14; 16 to 9), and corporal punishment scales (8 to 3; 7 to 3). The child also reported an improvement in PTSD symptoms on the UCLA PTSD Reaction Index (34 to 18), indicating that he no longer met criteria for a partial PTSD diagnosis. The chapter concludes with a summary of some of the benefits and challenges to using AF-CBT, and some recommendations for future work.

Kolko, D. J. (2015, April) Treating Emotional and Physical Abuse Using Alternatives for Families: A CBT. Paper presented in L. Berliner (Chair), Continuing to implement evidence-based trauma treatments: Lessons learned over the long-term. Symposium presented at the BASPCAN Conference, University of Edinburgh, Edinburgh, Scotland. (4/14).

This recent presentation reports an evaluation of the clinical or family effectiveness outcomes from the above-mentioned Partnership for Families Project in which 182 clinicians treated families following AF-CBT training or routine agency training (TAU). Data were collected from 195 caregivers and children who were assessed at months 0, 6, 12, and 18. Relative to TAU families, families seen in AF-CBT were more likely to receive treatment for physical force/abuse and had clinicians who directly addressed these problems. Further, AF-CBT families showed several improvements at the caregiver (e.g., less aggression, lower risk for abuse status, less family conflict; p 's = .05 to .001), family (e.g., less dysfunction; p 's = .05 to .001), and child levels (e.g., less behavioral dysfunction, more remission of child PTSD; less child to parent aggression; p 's = .05 to .001). Caregivers were less likely to use physical threats in AF-CBT as well. Most of these improvements were found for clinicians working in outpatient but not in-home settings. Most of the clinicians working in outpatient settings had several unique characteristics (e.g., more Masters degrees, more mental health backgrounds, more Caucasians, lower caseload size), relative to those in in-home settings (e.g., BA level, little mental health training, minority, larger caseloads).

We review key lessons learned about the sequencing of content and participants (child, caregiver, joint sessions), use of brief treatment modules, and the need to apply creative strategies to overcome negative reactions in therapy (e.g., hostility and callousness, abuse minimization, aggressive gestures). This presentation highlights suggestions for supervisory and senior leadership training, and the potential solutions to overcoming barriers to conducting AF-CBT (e.g., engagement, rapid assessment, psychoeducation, safety monitoring strategies, agency metrics, and homework practice assignments, motivation for change, outcome assessment).

CHILDREN'S BEHAVIOR PROBLEMS/DISORDERS- MENTAL HEALTH

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

This study examines the treatment outcomes of 144, 6-11 year-old, clinically referred boys and girls diagnosed with Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD) who were randomly assigned to a modular-based treatment protocol that was applied by research study clinicians either in the community (COMM) or a clinic office (CLINIC). The protocol was adapted from the key content modules in AF-CBT. To examine normative

comparisons, a matched sample of 69 healthy control children was included. Multiple informants completed diagnostic interviews and self-reports at six assessment timepoints (pretreatment to 3-year follow-up) to evaluate changes in the child's behavioral and emotional problems, psychopathic features, functional impairment, diagnostic status, and service involvement. Using HLM and logistic regression models, the two modular interventions (COMM and CLINIC) showed significant and comparable improvements on all outcomes (p 's = .05 to .001). By 3-year follow-up, 36% of COMM and 47% of CLINIC patients no longer met criteria for either ODD or CD, and 48% and 57% of the children in these two respective conditions had levels of parent-rated externalizing behavior problems in the normal range. These findings suggest that treatment in a clinic may be at least as effective as treatment in the community for children with behavior disorders.

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

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

PONI cases were significantly more likely to receive and complete mental health services ($p = .01$), had more weeks in treatment ($p = .050$, and attended more visits ($p = .001$). PONI cases also reported fewer service barriers ($p = .01$) and more consumer satisfaction ($p = .001$), and showed greater improvement in individualized goals ($p = .001$) and overall child health ($p = .01$), as well as remission for categorical behavioral disorders at one-year follow-up ($p = .001$). Both conditions also reported several significant improvements on several clinical outcomes over time (p 's = .02 to .001). A psychosocial intervention for behavior problems that was delivered by nurses in the primary care setting is feasible, improves access to mental health services, and has some clinical efficacy. Options for enhancing clinical outcome include the use of multifaceted collaborative care interventions in the pediatric practice.

Kolko, D. J., Campo, J. V., Kilbourne, A. & Kelleher, K. (2012). Doctor-Office Collaborative Care for Pediatric Behavior Problems: A Preliminary Clinical Trial. *Archives of Pediatrics & Adolescent Medicine, 166, 224-231.*

This study evaluated the feasibility and clinical utility of an integrated mental health intervention (Doctor-Office Collaborative Care, DOCC) vs. enhanced usual care (EUC) for children with behavior problems. Design: The first two of every three eligible cases were assigned to DOCC ($n = 55$) and every third case to EUC ($n = 23$). Initial assessment was conducted in one of six pediatric primary-care practices. Posttreatment assessment was conducted in the pediatric or research office. DOCC was delivered in the practice; EUC was initiated in the office but involved a facilitated referral to a local mental health specialist. Of 125 referrals (ages 5-12), 78 children participated. Children and their parents were assigned to receive DOCC or EUC. In terms of outcome measures, pretreatment diagnostic status was evaluated on the Schedule for Affective Disorders and Schizophrenia for

School-Aged Children, pre- and post-treatment ratings of behavioral and emotional problems were collected from parents on the Vanderbilt ADHD Diagnostic Parent Rating Scale and Individualized Goal Achievement Ratings form. At discharge, care managers and an evaluator completed the Clinical Global Impression Scale, and pediatricians and parents completed satisfaction measures.

Group comparisons found significant improvements for DOCC over EUC in service use ($p = .001$) and completion ($p = .001$), behavioral (p 's = .02 to .05) and emotional problems ($p = .59$), individualized behavioral goals, and overall clinical response (66% vs. 8%, $p < .001$). Parent and pediatrician reports were highly satisfied with DOCC.

Conclusions: The feasibility and clinical benefits of DOCC for behavior problems supports the integration of collaborative mental health services for common mental disorders in primary-care.

Kolko, D. J., Campo, J. V., Kilbourne, A., Hart, J., Sakolsky, D., & Wisniewski, S. (2014). Collaborative Care Outcomes for Pediatric Behavioral Health Problems: A Cluster Randomized Trial. *Pediatrics*. 133(4), April, e981-992.

This study assesses the effectiveness of a collaborative care intervention for behavior problems, ADHD, and anxiety in pediatric primary care (Doctor Office Collaborative Care; DOCC). Children and their caregivers participated from 8 pediatric practices that were cluster randomized to DOCC ($n = 161$) or Enhanced Usual Care (EUC; $n = 160$). DOCC incorporated a care manager who delivered a personalized, evidence-based intervention. EUC patients received psychoeducation and a facilitated specialty care referral. Care processes measures (e.g., treatment use, case status) were collected after the 6-month intervention period. Family outcome measures included the Vanderbilt ADHD Parent Rating Scale (VADPRS), Parenting Stress Index-Short Form (PSI-SF), Individualized Goal Attainment Ratings (IGAR), Clinical Global Impression-Improvement (CGI-I) at 6- and 12-month assessments, and the Consumer Satisfaction Questionnaire-8 (CSQ-8). Provider outcome measures examined perceived treatment practice change, efficacy, and obstacles, and practice climate.

In terms of the results, DOCC (vs. EUC) was associated with higher rates of treatment initiation (99.4 vs. 54.2%; $p < .001$) and completion (76.6 vs. 11.6%, $p = .001$). DOCC also showed greater reductions in severity of the child's behavior problems, hyperactivity, and internalizing problems on the VADPRS (p 's = .05 to .01), and parental stress ratings (p 's < .05 - .001), higher levels of remission in behavior and internalizing problems (p 's = .01, .05), improvement on IGAR targets (p 's < .05 to .001), and treatment response on the CGI-I ($p = .05$), and satisfaction ($p < .05$). DOCC pediatricians reported greater perceived practice change, efficacy, and skills use to treat ADHD (p 's < .05 to .01). Implementing a collaborative care behavioral health intervention in community pediatric practices is feasible and effective in improving clinical outcomes, further supporting the utility of integrated behavioral healthcare in pediatrics.

AF-CBT-RELATED REFERENCES

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