Attachment Based Family Therapy

Attachment Based Family Therapy for Depressed and Anxious Adolescents

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Sally is a 14-year old, referred by a psychiatrist whom in frustration recently changed her diagnosis from Major Depression to Bi-Polar Disorder and started her on a course of lithium. School failure, family conflict, intense sibling rivalry and a fascination with death-rock music were increasing. Six months ago, the depression had remitted somewhat, so the psychiatrists recommended the mother make more behavioral demands about school performance and cooperation at home. Conflict and isolation escalated.

She, her 16-year-old sister, and her mother attended the first session. She wore all black, heavy eye make-up, a metal choker, and several piercings in her ears. For the first 20 minutes she remained silent, only making insinuating gestures and groans of disagreement, while the mother compassionately complained about her daughter’s unpredictable behavior, indifference about school, fascination with violence, and her frustration over her failure to help her daughter.

Hoping to redirect the conversation from a focus on Sally to shared family struggles, the therapist asked about the father’s death ten years ago. Sally immediately asserted she was glad he died, which raised protest from her sister and mother. After showing some sincere interest in her feelings about the father, Sally revealed that the father had become a depressed alcoholic who physically abused the mother. After some minimizing statements, the mother admitted to the violence and how bad things had been. The therapist pointed out that Sally’s hatred towards her dad also expressed protectiveness towards her mom. Over this, Sally began to cry and talk about her
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worries about mom then and now. The mother seemed uncomfortable with her
daughter's empathy toward her. Perceiving the mother's discomfort, Sally returned to
complaining about the father. The therapist redirected Sally back to her more vulnerable
feelings by noting how hard it was to show love and concern for her mom. Sally's mood
softened again and she began to discuss how they had grown apart and rarely spent
time hanging out together. Mother said she assumed the daughter was too old for that,
to which Sally responded, "I will never be too old for that." At this juncture, the therapist
complimented Sally's willingness to discuss difficult issues that others wanted to avoid
and punctuated her feelings of missing her mom. The therapist also empathized with
the mother's confusion about how to be close to her daughter while also establishing
expectations. Finally, the therapist suggested that the first goal of treatment focus on
going reconnected with each other. This way people would understand each other
better, not feel so alone, and the daughter would have someone to talk to when she was
depressed or suicidal. Both the mother and Sally agreed to this treatment focus.

This first session embodies many of the principles and goals of Attachment-
Based Family Therapy (ABFT; Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002).
Depressed adolescents usually come to therapy feeling hopeless, alone, and angry at
their parents for misunderstanding their despair. Parents, with their own ambivalence
about, and struggle with, attachment and intimacy, feel frustrated over their failure to
help their child. However, the generationally-shared wounds caused by attachment
failures are often obscured by conflicts over behavioral problems. It is safer to argue
about chores or homework than abuse, abandonment, and neglect. Even in families that
display closeness and open communication struggle with maintaining these strengths in

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the face of a major depressive episode. Identifying and discussing these relational
ruptures, and the painful emotions associated with them, creates an experience of
shared vulnerability and authenticity that can rekindle the natural desire for attachment
(adolescent) and caregiving (parent). Empathic, non-accusatory conversations about
attachment failures become the context for teaching and practicing more effective
conflict management and affect regulation skills, expressing contrition and forgiveness,
and renewing trust between family members.

This chapter provides a brief overview of the ABFT approach. It begins with a
description of the theoretical foundations of the model. Then a detailed description of
the five treatment tasks, along with the logic underlying each, is provided. Empirical
support for ABFT with depressed adolescents is briefly reviewed. Then, the adaptation
of ABFT to working with anxious adolescents is offered, and preliminary pilot data is
presented. Because ABFT has been tested primarily with inner-city African American
clients, the chapter also provides a brief discussion of some cultural issues that inform
the application of the model. We conclude with a brief summary of the next few
sessions of the case presented above.

The Theoretical Base

Attachment Theory. Attachment Theory (Bowlby, 1969) offers an alternative
theory base to General Systems or Cybernetic Theory for understanding the
Interpersonal dynamics of family life. These models were critical in helping therapists
shift focus from individuals to systems and from symptoms to interaction. While
revolutionary at the time, these theories assumed that families functioned as biological
or mechanical systems. Family therapists in search of more relationship-based models have turned to Attachment Theory (Bowlby, 1969) to better explain human motivations, emotions, and behaviors (see Johnson & Whiffen, 2003, and Wood, 2002).

Attachment Theory rests on the assumption that a child’s sense of security in life depends on parents being available and protective. When a parent appropriately responds to this need, the child generally develops a secure attachment style. This attachment/caregiving system is essential for survival and thus is a hardwired, biological instinct. While much of the attachment research has focused on infants and young children, the importance of appropriate attachment throughout the lifespan has been well-theorized and documented (Ainsworth, 1989; Steinberg, 1990). For adolescents in particular, secure attachment nurtures healthy development, while insecure attachment has repeatedly been associated with depression and other kinds of functional problems (Kobak & Sceery, 1988; Rosenstein & Horowitz, 1996).

For adolescents, attachment is maintained (and possibly revived) when three interpersonal elements exist. Adolescents must feel they have access to caregivers when needed. They must also feel free to openly communicate without the fear of rejection or judgment. And finally, adolescents must feel that parents can protect them, not just from physical harm, but from emotional harm as well (Kobak, Sudler & Gamble, 1991). When these conditions are met, adolescents are more likely to feel secure and safe. With this foundation in place, adolescents show greater autonomy seeking behavior, positive peer relations, and higher self-esteem (Allen & Land, 1999). They also freely express negative or vulnerable emotions (e.g., fear, anger, distress) with the expectation of acceptance and comfort, rather than criticism and abandonment. In fact,
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Kobak and Duemmier (1994) found that secure attachment leads to more direct communication, which fosters perspective-taking and problem-solving skills. In this regard, adolescent attachment theory parallels the now empirically supported view that an appropriate balance of connection to and independence from the family is the central task of adolescent development (Allen & Land, 1999).

One challenge in an attachment-based family intervention approach is in building the parents' capacity for providing security-promoting parenting. Many parents of depressed adolescents were denied adequate parenting as children and consequently have insecure attachment styles themselves. These parents often feel ambivalent, anxious, or incapable of providing comfort, soothing, and reassurance. In these families, the expression of negative, vulnerable feelings is unwelcome and unsafe. When caretakers are unavailable and unresponsive, particularly at critical moments, they can become a source of emotional injury, rather than a foundation of safety and support (Kobak & Mandelbaum, 2003).

Lacking confidence in the safety of interpersonal relationships, adolescents fail to develop effective problem-solving skills. Instead of addressing conflict and disappointment directly, they protect themselves with conflict avoidances, denial, and other cognitive distortions. Emotional energy becomes preoccupied with preserving fragile and dysfunctional relationships. In fact, depressed adolescents often “protect” parents from angry or sad feelings, fearing that honesty would overburden their parents or lead to further rejection (Diamond & Siqueland, 1998). Consequently, adolescents express anger about core attachment failures indirectly through conflicts over day-to-day behavioral problems (e.g., chores, curfew, etc). Depressed adolescents also have a
tendency to blame themselves for these attachment failures and view themselves as unworthy of love and affection. This can promote a negative schema of self and others, putting them at greater risk for depression (Cicchetti, Toth & Lynch, 1995).

Repairing Attachment. In contrast to the psychoanalytic tradition, Bowlby posited that internal working models, although persistent, were open to revision across the lifespan (Bowlby, 1969, 1988; Waters, Kondo-Ikemura, Posada & Richters, 1991). Not only can negative life experience damage one's felt security, but positive life experience can help rebuild it. Several studies have now found that good parenting, a loving marriage, or a positive therapeutic experience increases one's sense of felt security (Cicchetti & Greenberg, 1991; Weinfeld, Sroufe, Egelund, 2000). Main and Goldwyn (1988) characterized this process as "earned security." Individuals victimized by negative parenting can earn security by working through and coming to terms with these experiences. Interestingly, adults with earned security remain as susceptible to depression as adults with insecure attachment styles, but they have parenting practices similar to adults with secure attachment thereby. Good parenting thus buffers against the negative impact of the parents' depression (Pearson, Cohn, Cowan & Cowan, 1994). In this way, parents or adolescents who can resolve these attachment failures can develop interpersonal skills and strengths that promote healthier living.

While adult attachment research has primarily focused on the consequence of negative internal working models, how to earn a secure attachment style has not been well spelled out. Research and theory on forgiveness and trauma resolution provide some insight into this process. The process of forgiveness has been characterized as a) experiencing strong emotions, b) giving up the need for redress from the perpetrator, c)
seeing the offender as distinct and separate from one's needs and identity, and d) developing empathy for an offender (McCullough, Pargament, & Thoresen, 2000). Although AFBT focuses on exoneration rather than forgiveness, these processes characterize many of the therapeutic domains traversed during the attachment task. Herman's (1992) model of trauma recovery also delineates several steps toward resolving trauma experiences. These steps include a) restoring a sense of control, b) establishing safety, c) telling the trauma story in detail, d) mourning losses, and e) reconnecting with self and community. ABFT helps family members collaboratively participate in conversations that achieve similar goals.

Studies on adolescent affect regulation and family interaction also offer insights into the process of earned security (Allen, Hauser & Borman-Spurrell, 1996). In particular, Kobak and Sceery (1988) suggest that while behavioral interactions between parents and children shape early attachment security, given adolescents' emerging cognitive capacity, conversation increasingly becomes the mechanism through which attachment security is experienced and negotiated (Kobak & Duemmier, 1994). Thus, the ABFT model proposes that direct conversations about relational failures may be a key vehicle or mechanism through which family members earn or develop a secure attachment style.

Conversations about relational trauma become the enactment within which families have a corrective attachment experience. Children who have been treated unjustly, be it physical or psychological abuse, internalize a model of self as unworthy of love, and of other as untrustworthy (Bartholomew & Horowitz, 1991). Therefore, rather than appropriately seeking redress for interpersonal injustices, they act out destructively.
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towards themselves or others. Alternatively, helping adolescents identify, articulate, and appropriately talk about these relational ruptures challenges their hopelessness and helplessness, increases their tolerance for emotional conflict, and promotes an appropriate sense of entitlement to healthier relationships. For parents, these conversations offer an opportunity to provide effective caregiving (sensitivity, emotional protection, empathic listening). If successful, these intense, emotionally charged encounters offer an opportunity to provide comfort and protective parenting. This helps the adolescent rebuild trust in the parents' capacity to provide a secure base. In ABFT, like Contextual Therapy, repairing trust and reestablishing fairness between family members is a primary therapeutic target (Boszormenyi-Nagy & Sparks, 1973). These kinds of corrective-attachments experienced directly with caretakers (and ideally sustained improvement in parenting behavior) may alter both day-to-day interactions between family members, and parents' and adolescents' interpersonal schemas about self and other (see Weinfield, Sroufe & Egeland, 2000).

Clinical Foundation

ABFT is rooted in the structural tradition with some recasting of the basic concepts. For instance, reestablishing hierarchy in the traditional sense (e.g. parental control) is not the driving theme. Rather, promoting authoritative parenting skills (warmth, acceptance, demanding behaviors, clear expectations; Baumrind, 1991) and a more age-appropriate, mutual communication, serves as one primary treatment goal. In addition, reframing and enactment remain primary intervention strategies. Reframing aims to restructure how patients think about or explain a problem, ideally leading to
cognitions that promote more positive behavior. In ABFT, reframing has a specific goal: shifting the family's focus from "the patient as the problem" to "the family as the cure." Enactment may be the most innovative contribution from the structural tradition. Rather than clients resolving interpersonal conflict through transference with the therapist, family therapists facilitate conversations directly between the family members themselves. In ABFT, enactments are engineered to specifically and systematically focus on specific content and affect: family trauma and vulnerable emotions.

Clearly the most profound impact on ABFT has come from Multidimensional Family Therapy (MDFT), developed by Howard Liddle (Liddle, 1999; Liddle, Dakof, Parker, Diamond, Barrett, & Tejada, 2001). MDFT also emerges from the structural tradition, but brings to family therapy the informative knowledge base of family and clinical psychology. In this regard, interventions in MDFT are informed by research on child and adolescent development and psychopathology, parenting, cognitions, emotions, social learning, and attachment theory and other specialty areas. This empirical and theoretical orientation provides a new depth and understanding to the change processes involved in family therapy. In many ways MDFT offers a system of thought about family treatment that can be used to understand any family intervention model. MDFT also provides one of the first developmentally informed approaches to working with adolescents. Traditional structural family therapy focused on establishing parental hierarchy is the first, if not ultimate, goal of therapy. Appreciating the adolescents' developmental need to feel respected and understood, MDFT therapists set out to actively engage adolescents in the treatment processes as the first agenda of treatment (Liddle & Diamond, 1991). Helping adolescents identify problems that are
meaningful to them, and helping parents take these concerns seriously, is a hallmark of MDFT and a fundamental principle in ABFT.

Focus on affective engagement, education, and processing is an essential tool in ABFT. In the last decade, many individual and family therapists have begun to write about the importance and use of emotions in therapy. Emotionally Focused Therapy (EFT: Greenberg & Johnson, 1988) has been at the forefront of understanding and using emotion as the core intervention mechanism. Relying on contemporary research on emotion, EFT therapists assume that while the expression of affect may be cathartic, it is also a primary signaling system that serves a communication function (Greenberg & Safran, 1987). For example, anger usually makes others defensive and thus creates distance and separation. On the other hand, sadness and pain tend to communicate the need for support and thus can evoke protection and compassion. Clearly, affect and cognition are linked. Core emotions develop in tandem with cognitions that emerge from strong (positive or negative) experiences. Core traumatic experiences generate a cognitive-affective schema that can organize future behavior. Creating conversations where these “hot cognitions” are re-evoked, creates a profound learning environment for the inspection, clarification, and modification of these affect-laden, core events.

Hot cognitions arise from core conflicts that drive underlying anger and animosity (“I still hate you for what you did to our family.” “If you treated him better, Dad might not have left.” “Even though you are sober now, I will never forgive you for being drunk all those years.”). When these kinds of affectively charged memories and cognitions haunt the family, avoiding them in therapy may derail or stall treatment. In particular, a focus on behavioral goals (e.g., parental supervision, rules and expectations, etc.) often falls if
adolescents hold an emotional grudge against their parents for past injustices. In fact, adolescents often use behavioral conflicts to punish parents for past attachment failures and betrayals. Although families often avoid these topics, they usually feel relieved to finally address them in therapy, like the unburdening of a secret that everyone knows but never discusses. In many families, merely identifying and acknowledging these topics helps diffuse tension and distrust.

At the skill-building level, sustained discussion of vulnerable and painful emotions creates a learning environment within which to exercise new interpersonal skills that have been promoted throughout the therapy. Parents have the opportunity to provide empathy, compassion, understanding, and reassurance -- the core competencies of attachment-promoting caregiving. Simultaneously, adolescents practice putting emotions into words, addressing difficult problems in a direct and mature manner, tolerating difficult emotions, and discovering that relationships can withstand emotional challenges. In this regard, these conversations create a corrective attachment experience.

Clinical Structure of ABFT. Based on the theoretical formulation described above, ABFT treatment focuses first on helping the family identify and discuss past and present conflicts that have violated the attachment bond and damaged trust. Once some of these issues have been diffused, if not resolved, the family can serve as a secure base from which to promote adolescent autonomy (e.g., improving school performance/attendance, finding a job, developing or returning to social activities). To achieve these goals, five treatment tasks have been developed. A task is a discrete episode with a defined set of therapist procedures for addressing specific patient
problem states. Tasks may occur in a single session or, if needed, evolve over several sessions. In ABFT, the full or partial success of each task forms a foundation for future tasks (Diamond & Diamond, 2002). Although the ABFT model provides a recommended order and unique structure for each task, implementation requires constant assessment, judgment, and flexibility by the therapist. For example, relationship and trust building can occur between a child and a primary caregiver, be it a single parent, a grandparent, or a foster parent. We briefly summarize the five tasks and then provide more detail on each.

The Relational Reframe Task sets the foundation of treatment by shifting the family’s focus from “fixing” the patient to improving family relationships (Diamond & Siqueland, 1998). The Adolescent Alliance Building Task usually occurs alone with the patient in order to strengthen the therapist-patient bond, develop meaningful individual and family focused treatment goals, and convince the adolescent to discuss core conflicts with his or her parents. The Parent Alliance Building Task explores personal stressors and family-of-origin history that may affect parenting (Diamond, Diamond & Liddle, 2000). When parents feel and receive empathy for their own history of attachment failure, they become more compassionate toward their child’s traumas and felt injustices. In this softened state, they are more receptive to learning the emotional coaching parenting skills (Gottman, Katz, & Hooven, 1996) needed to facilitate the attachment-repairing task.

These first three tasks set the foundation for The Attachment Task (Diamond & Stern, 2003). In this task, the adolescent discloses his or her concerns, while the parent responds with sensitivity and empathy. Monologue turns to dialogue as
adolescent and parent develop a new, more mature capacity for conversation. This
discussion fosters mutual acceptance of the other's failings, as well as a shared
commitment to future respect and communication. Finally, The Competency Promoting
Task helps the adolescent rebuild his or her life at school and with peers, using the
parents as a new secure base from which the adolescent can explore his or her
autonomy and competency.

The Clinical Model

Task One: Relational Reframing

The relational reframe shifts the goal of therapy from a focus on blaming the
depression or the adolescent as the cause of the problem to strengthening family
relationships as the solution to the problem. Essentially, this redefines the initial focus of
the therapy from fixing the child or the depression to rebuilding the adolescent's
attachment to parents and reviving parents' caregiving instincts. The intent of the
reframe is to develop problem definitions that a) reduce parental blaming and criticism,
b) increase parental support and concern (e.g., he is not a bad kid but a sad kid), and c)
put the responsibility for change on all family members.

Helping family members accept relationship building as the initial goal of
treatment can be a formidable task. Parents often want to blame their child (e.g., he is
lazy, mean, or selfish) or view depression as an excuse for negative behavior. Even
when parents understand the depression, they often assume they have little ability or
responsibility for changing it (i.e., "It's a medical problem. He should just take his
medicine."). Simultaneously, the adolescent's depression reinforces isolation, distrust,
and indifference, mood states that thwart relationship building. Adolescents also
complain that parents are impatient, controlling, critical, and overbearing. More
importantly, often long-standing interpersonal conflicts and attachment failures have
resulted in deep-seated resentment and disappointment. Consequently, many
adolescents have given up on having a relationship with their parents, either out of
resentment or self-protection. Given these dynamics, parents and adolescents are, at
best, ambivalent about reattachment. Therefore, the process of developing this
therapeutic agenda must be focused and strategic.

The initial session follows many of the procedures and goals that characterize
many family therapy models. These goals begin with building multiple alliances. The
therapist must help each family member feel that his or her unique opinions and needs will
be taken seriously. Second, the session or task focuses on reframing the problem
definition. In general, reframing refers to helping the family develop a more constructive
definition of the problem that brought them to therapy. For ABFT reframing specifically
refers to helping the family adopt a more systemic or relational goal for the therapy. Rather
than fixing the patients, treatment will focus on repairing family trust and communication.
This goal is framed as the family’s initial step toward helping the adolescent manage and
reduce depression and suicide ideation. Finally, the session should end with the
establishment of a therapy contract. This is essentially a punctuation of the reframe: the
family members agree to work on rebuilding relationships.

Typically, the therapist begins the session by orienting the family to the overall
therapy process and specific goals for the first session. Clarity about the structure, the
timeline, and the expected goals of treatment convey competency and authority.
Families want to work with therapists who know what they are doing. The therapist then focuses on joining and getting acquainted with each family member. Time is spent talking with each family member about their individual lives independent of the problems that brought them to therapy (e.g., work, hobbies, relationships, etc.). These questions help the family begin to feel comfortable, acknowledge that families are more than just their problems, and reveal interesting details about family members that can be used later in treatment.

With a clear shift in intention, the therapist then elicits a description of the problems that have brought the family to treatment. Initially, the therapist focuses on fact finding: the specifics of the depression, when it started, who has been involved, the most recent events, and previous attempts to manage the problem. The therapist must always have a systemic perspective in mind and focus on how the quality of relationships and patterns of interaction contribute to the depression. For example, the therapist might ask each family member his or her opinions about what different family members do and feel in response to the depression. The therapist also tries to examine and gather information about the wider context of both the family’s problems and supports. The therapist asks about the family’s involvement with extended family, church, school, community, social services, and the legal system.

Once the therapist has a general understanding of the depression and how it affects the family, he or she begins to set the foundation for the reframe. To accomplish this, the therapist begins to shift the discussion from fact finding to an understanding of the family’s attributions about the problem. The pacing of this switch depends on multiple factors, including the condition of the alliance with each family member and the

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family's general readiness to consider how family relationships may affect and help resolve the depression. However, therapists should not be too timid in guiding the process in the desired direction; families are looking for professional leadership.

The pivotal moment of the relational reframe interventions generally begins with some version of the following question from the therapist: "When you feel so depressed or suicidal, why don't you go to your parents for help? Why can't you use them as a resource?" This question directs the discussion away from a focus on the patient and symptoms and toward a focus on the quality of the relationship between family members. Adolescents often report that parents are not good listeners, always try to fix things, or just don't care. Rather than feeling comforted and reassured, adolescents feel unheard, dismissed, or invalidated. To circumvent the inevitable parental defensiveness, therapists identify and amplify the adolescent's primary emotions beneath the frustration and blame, typically loneliness and abandonment. For instance, the therapist might say, "Although you sound angry, you also seem a bit sad."

Aiming to remain focused on more vulnerable emotions, the therapist may ask the parent, "Did you know your child feels alone most of the time?" Parents may claim awareness of these feelings, but complain that the adolescent refuses to discuss them. Here the therapist can acknowledge the parent's efforts and empathize with the difficulties of raising a depressed adolescent. If the parent does too much, they are perceived as controlling. If the parent does too little, they are perceived as abandoning. It can feel like a no-win situation. The therapist must contain the parent's feelings of anger and frustration and amplify feelings of disappointment and loss. Focusing parents on vulnerable emotions activates their biologically hardwired, caretaking, empathy, and

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protection (Gottman, et al., 1996; Johnson & Whiffen, 2003).

In some cases, the conversation can continue. However, often the therapist may want to lay more groundwork before exploring this further. The session culminates by punctuating that repairing this relational disconnect may provide some support and comfort for the adolescent when faced with future depressive or suicidal thoughts. In this sense the relational failure is not touted as the cause of the depression (though sometimes it is), but rather that repairing these ruptures is one important step toward reducing the depression. At the end of the hour, the therapist may punctuate the session with some version of the summary and request described below.

It sounds like many things are contributing to your depression. Certainly, your struggles with schoolwork, reading, and math are frustrating. We want to figure out how to help you with that. And, you seem very isolated, like you have lost all your friends... Life gets very hard when you're depressed, right? (Patient nods her head in agreement.) But there are also some painful things between you and your mom, almost too painful for you to discuss. The deep love you two feel for each other has been buried under a lot of pain and resentment. Would you agree? (Nods her head again.) It is OK if you are not ready to talk about this. After all, we have just met. But I wonder if you would meet alone with me next week, and help me understand what those tears are about. Do you think we could talk about that together without mom here? (She agrees, but continues to hold her head down).

Good. Once we understand that better, we can think together about what gets in the
way of talking to your mom and dad about these things. Because I firmly believe that
(turns to mother) when kids are depressed, parents can be a tremendous help to them. I
think your daughter feels very alone with a lot of pain. She has no one to talk with, to cry
with, and to share all the things that are on her mind. Instead it just builds up.

And it sounds like you (mom and dad) have tried to be helpful, but it is hard to know
how (they agree). I would like our first goal of treatment to be helping the three of you
reconnect. Help you two (parents) work better as a team and help your daughter talk
with you about what has gotten in the way of trusting you. I want your daughter to feel
safer at home. Would you be willing to work with me on this?

Task Two: Building Alliance with the Adolescent

The alliance-building task with the adolescent is a critical goal in and of itself and
is the setup for future tasks. Unlike younger children whom parents can easily bring to
treatment, adolescents make a strong contribution to whether or not they attend and
engage in treatment. Therefore, if adolescents feel the therapist can understand,
support, and even defend them, they will more likely give treatment a chance. However,
alliance formation is not about being nice. It is about being perceptive, incisive, and
knowledgeable. Alliance develops when a therapist knows what he or she is doing,
remains focused in the face of chaos, empathetically speaks the truth, and has high
expectations for change.

To build this alliance, the initial phase of treatment focuses on the adolescent as
a victim of circumstance. We intentionally side with the adolescent’s feeling of abuse,
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neglect, disrespect, being put down, and/or blamed. In doing this, we connect with a side of the adolescent that has rarely been acknowledged (Liddle & Diamond, 1991). Depressed teens can be complainers, irritable, and non-communicative, which often makes it hard for parents to take their claims of injustice seriously. Consequently, depressed adolescents often feel compelled to fight in order to be heard. Therefore, therapists must identify and acknowledge these felt injustices in order to free the adolescent from the battle for recognition. Until the depressed adolescent feels heard, understood, and appreciated, he or she will often not allow a therapist or parent to challenge or hold him or her accountable for behavior. In this regard, although we initially join with them as victims, once we are in, we challenge the adolescent to respond to these stressors in more direct, productive and less depressogenic ways.

As a general guideline, this task consists of three components. Based on Bordin's (1979) tripartite definition of the therapeutic alliance, the three phases of the alliance-building process are: a) establishing a bond, b) identifying meaningful treatment goals, and c) agreeing on the tasks to achieve these goals. For each of these components or tasks, the therapist has specific foci and desired outcomes. The ultimate goal of the session is for the adolescent to admit to being unhappy, express a desire for change, and agree to address these conflicts with his or her parents.

There are three different elements to forming a bond. First, the therapist focuses on getting to know the world of the adolescent (Liddle, 1999). The therapist shows curiosity about the teen's interests, hobbies, friends, music, and his or her thoughts and feelings about these areas. Problem areas like depression, family conflict, or school failure are reserved for later discussion, and in fact, are often avoided (e.g., "I'm
interested in that, but let me hear a bit more about your dance performance!"). Depressed adolescents (and many therapists) overly focus on problems. A focus on positive aspects is surprising and refreshing. Second, the therapist wants to identify and highlight strengths. Amplifying strengths and skills makes these aspects of the adolescent more accessible to the therapist. The third, the therapist seeks to shift the adolescent's view of the therapist from an authority figure to an ally. In this regard the therapist will serve as a transitional relationship, renewing the adolescent's hope that a helpful and mutually satisfying relationship with adults is possible.

The second component of alliance building focuses on establishing the adolescent's goals for treatment. This begins by asking about the adolescent's concerns, worries, and goals for treatment. To help engage a passive and depressed adolescent, the therapist must transform the usual complaints into more meaningful and substantial themes. For example, wanting more freedom to choose their clothes or keep their room a mess is interpreted as needs for autonomy and respect. In general, the therapist is always looking to identify the broader interpersonal themes that help make the specific details more meaningful (Diamond & Liddle, 1996, 1999).

Details about the depression remain important. Therapists may ask about symptom severity and diversity, duration, suicidal ideation, and impact on home, school, and social functioning. This can serve two goals. Therapist can use this information punctuate and acknowledgment the adolescent pain (e.g., "So you are more unhappy than your parents know."). In addition, the therapist can use this information to help combat denial and resistance (e.g., "So even though you said things were OK, you are really unhappy."). Once the misery is clearly understood, the therapist can introduce a
pivotal question: "So given how unhappy you are, how interested are you in trying to change this? How to change is another question, and we will get to it. What I want to know at this point is whether you want things to be different?" Ambivalence or resistance to change is countered by reminding the adolescent of the misery he or she just described. Ideally, their unhappiness becomes the motivation for change, rather than external pressures. When hopelessness about change is encountered, the therapist must inspire more hope and optimism by saying things like: "I am not hopeless. I am an expert in helping kids like you! I know how to get these things done!" The desired outcome of this phase is that the adolescent says, "Yes, I would like things to be different." Acknowledgement of this desire provides leverage against latter resistance, whereby the therapist can say, "Remember two weeks ago, you said you wanted things to change? Well that is what we are trying to do now. Don't give up so easily! Fight for what you want!" The therapist can also use vulnerable emotions to help combat this resistance (e.g., "You are saying it doesn't matter, but I can see the pain and disappointment in your face.").

Next, the therapist gently moves the conversation towards repairing attachment. The therapist might ask the following: "Do your parents know about or understand how much you are suffering? When you feel this bad, why don't you turn to them for help? What events have happened in the past that have damaged trust between you and your parents?" These questions are pivotal in moving the conversation from an intrapersonal focus to an interpersonal focus. In response, adolescents will often identify critical events (i.e., abuse, abandonment, neglect) or processes (i.e., overly critical or
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controlling). Associating these problems with the adolescent's depression is ideal, but defining them as pivotal causes of damaging trust is the essential goal of the session.

Once some of the affectively charged trauma experiences have been identified, the therapist can introduce the central question of the session: "Have you ever told your parents about these problems?". If the adolescent has not, then the therapist can explore further the distrust and the anticipation of what would happen if they did. Adolescents often fear that parents will not listen or be interested. The therapist can then recap the logic of the conversation to help the adolescent agree to the task. Some version of the following statement might be said:

"Look, you told me that you are miserable, right? That you are so unhappy with your life that you sometimes think about killing yourself, right?... You also said that you wanted things to change... You also said that the things that you have done in the past to try to create change did not work and that maybe you do not know how to make things better by yourself, right?... Well I have some new ideas, some new things for you to try. For instance, I think your parents need to know the things that you are telling me. They have a very different understanding of the situation. They think you are the problem and until you can be honest and direct with them, they never have to take you seriously. Does that make sense? I think we should plan for a meeting together where you talk and they listen. They need to hear these things and you need to get them off your chest. What do you think about this? What do you have to lose?"

The logic set out above is the centerpiece of the adolescent-alone alliance-building session. All the previous discussions have lead to this moment. If the
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groundwork has been well laid, then this recommendation is just the natural conclusion to a long conversation. If the adolescent agrees to the task, the therapist might spend time preparing him or her for the conjoint session. If the adolescent remains resistant, the therapist reworks themes from earlier in the session. The most common resistance is that mom or dad will not listen or care or they have tried in the past and it has not worked. Again, the therapist must lend optimism by saying, “Yes, but you have never done this with me before. I can help them listen. I will prepare them. I can get them ready.” If agreement still cannot be made, the therapist may scale back his or her goals and merely ask the adolescent to think about this over the week and come to the next session.

Task Three: Building Parent Alliance

The alliance-building task with parents alone is an essential component of the attachment repairing process and the therapy in general. If nothing more, alliance with the parent increases the likelihood that a family will remain in treatment (Diamond, Shelef, Diamond, Liddle, in press). The parent, not the adolescent, typically initiates treatment, pays for treatment, and brings the adolescent to treatment. Therefore, if the parent-therapist alliance is weak, the parent is more likely to give into the natural resistance voiced by the adolescent.

In addition to retention, the parent-therapist alliance sets the essential foundation for future attachment-repairing work. Therefore, in ABFT, parents are the client as well as the adolescent. Parents of depressed adolescents often have insecure attachment styles resulting from their own history of attachment failures: inadequate parental care,

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neglect, or abuse. This, compounded with other potential problems such as marital
distress, psychiatric problems, or financial stress, compromises natural caregiving
instincts and skills (Kobak & Mandelbaum, 2003). Although the ABFT therapist does not
attempt to launch a full course of individual treatment for the parents, the parents’
current and past attachment insecurity become leverage for the current treatment goals.
Helping parents acknowledge and sympathize with their own losses, disappointments,
and pain prepares them to be more empathetic to their adolescent’s current experience.

Like the adolescent alliance task, the parent alliance tasks can also be
conceptualized as consisting of bonds, goals, and tasks. The bond phase has three
goals. First, the therapist must set a tone of support and empathy. This is especially
important given that early sessions tend to side with the adolescent’s concerns. This
imbalance can be addressed directly early in the session (e.g., “I am glad we have a
chance to meet alone. I know it appears that I have sided a bit with your son, but we
find this is often necessary to engage an adolescent in treatment. Does that make
sense?”). After this is discussed, the therapist turns to a focus on the parent (e.g., “I
would like to spend a little time getting to know you a bit more, you know, what is going
on in your life.”). Like with the adolescent, the therapist should try to identify strengths
and resources that will provide a broader definition of the parent, both as a parent and
as an independent adult. As parents feel admired and recognized as competent, they
are more willing to share their vulnerabilities.

The therapist begins to explore the stressors that impact general functioning and
parenting specifically. Discussions usually focus on depression, substance use or other
psychiatric problems, marital distress, stressful life events, or financial problems. The
therapist explores the impact of these stressors on the parenting process, if not the adolescent’s depression itself. The therapist might probe with statements like, “It must be hard to raise a depressed teenager when you are struggling with all this,” or “Do you think your depression or marital conflicts are affecting your daughter?”). These questions cannot be perceived as blame, but must be experienced as empathic explorations. The goal is not to necessarily resolve these issues, but to show interest, express empathy, and offer some recommendations (i.e., referral for therapy or case management). For many parents, this is more support than they usually receive or would have sought for themselves independent of their adolescent. In addition, the therapist’s empathy increases the likelihood that the parent’s vulnerable emotions associated with these challenges will surface. In this softened state, parents become more likely to empathize with the adolescent’s concerns.

In the bond phase of the sessions, discussions also focus on the parent’s own experience of being parented. These conversations begin with questions like, “So what kind of relationships did you have with your parents?” If trust has been established, parents willingly describe the strengths or limitations of their own childhood experience. While this conversation could be endless, the therapist is guided by the goal of identifying information that will create parental sympathy for the adolescent. For instance, if the parent had a good relationship with his or her parents, the therapist might say the following, “You know how rewarding this kind of closeness can be. It must be disappointing that you don’t have that with your child.” Alternatively, when parents had an insecure attachment experience, the therapist might say, “So you know how
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painful it is for a child to feel estranged from his or her parent. I wonder if this is how your daughter feels?"

The bond phase sets the foundation for the goal phase. Ideally, the parent is in a softened, self-reflective mood with a deeper appreciation of how relational failures can negatively impact a child. The discussion then turns to how current or past stressors in the parent's life may impact his or her emotional availability for the child. The intent here is not to blame the parent, but to express empathy for how difficult it is to parent a depressed adolescent when one is overwhelmed, depressed, or has never experienced adequate parenting him- or herself. With this foundation, the therapist can introduce the goal of the attachment task with the following kind of statement: "You know... you have had many disappointments in your life. Some you have survived well and others have scarred you for life. Worst of all, you have had few people to turn to for help and support. Right?... I think your daughter is struggling with some similar things. Feeling hurt and alone. I wonder if you would like to rescue her from the darkness that you had to struggle with. You could reach out to her in ways your mother never did." This invitation offers parents an opportunity to interrupt the generational pattern of neglect and emotional isolation. It does not blame the parents, but it promotes them as capable of soothing the child's despair and hopelessness.

The challenge here however is that many of the core concerns and complaints from the adolescent may be directed at the parents themselves. The sell to the parent is that the adolescent's strong feelings about these relational failures keep him or her from talking to or trusting the parent. Helping the adolescent to get these feelings off his or her chest (regardless of their accuracy) may serve to diffuse some of the tension.
between them. When this phase is executed successfully, parents express willingness
to listen to their adolescent's grievances in the hope that it will open communication.

If parents sign on to the goal, the remainder of the session is spent preparing for
the task. What role should the parent have? Do they say anything or just listen? Do they
defend themselves or tell their side of the story? To deliver an answer to these
questions, the ABFT therapist uses the framework of the emotional coach promoted by
Gottman and colleagues (1996). Emotional coaching essentially teaches parents
empathic listening skills. Discussions begin with a focus on the parents “meta-
emotions”: their theories, beliefs, feelings and attitudes toward emotions in general and
negative emotions in particular. This discussion may again have an intergenerational
focus by exploring how emotions were handled in the previous generation. After
understanding the parents’ past approach to emotions, the therapist begins to educate
parents about the value of emotions and children’s need to learn how to identify,
express, and manage them. Better emotional functioning encourages cooperation and
problem solving, builds self-esteem, facilitates the learning of communication skills,
serves as the foundation for intimacy, improves one’s capacity to manage stress, and
even improves social, academic, and physical health (Gottman et al., 1996)

Once this philosophical battle is won, therapist can teach some concrete, specific
and simple emotional coaching skills to help the parent during the attachment
conversation: Give your child full attention. Do not be distracted. Listen to your child and
try to understand what they are saying from their point of view. Ask questions rather
than make statements. Show curiosity. Accept whatever emotions they express. Do not
try to talk them out of how they are feeling. Try to listen for vulnerable emotions

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underneath anger. Help them label emotions. Use reflective listening; say back to them what you have heard. Share simple observations and, in a limited fashion, share examples from your own life.

By promoting attachment-based caregiving skills, the therapist accomplishes three goals. First, the therapist transforms the parents’ intention (motivation) to criticize, blame or fix the adolescent into desire to offer protection and comfort. Second, the therapist uses this opportunity to teach or broaden parenting skills to include empathy and warmth. Third, the expression of appropriate caregiving skills creates a new and unfamiliar, yet sorely needed, moment of intimacy between the parent and adolescent. Therefore, this discussion serves to momentarily resuscitate the attachment/caregiver bond that is typically tarnished in these families.

Task Four: The Attachment Task

This task builds on the foundation established in earlier tasks. Previous sessions have developed new problem attributions, established strong alliances with all family members, identified core conflict themes, and solidified the commitment to engage in a dialogue about attachment failures. With this foundation set, the therapist initiates the attachment task at the outset of the session. If the foundation is unstable, the therapist may postpone the enactment of this conversation. Alternatively, the conversation itself may solidify the foundation. This task can be conceptualized as three phases: adolescent disclosure, parent brief disclosure, and parent adolescent dialogue (Diamond & Stern, 2003).

If willing, the adolescent begins the session by presenting his or her grievances.

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This usually concerns chronic family conflicts or traumas such as abandonment, abuse, or neglect. Although challenging for parents, the adolescent's direct expression of anger is often welcomed over their typical avoidant, flat, or withdrawn presentation. The therapist encourages the parent to elicit details of the adolescent's grievances, while the therapist helps him or her articulate these concerns in a mature, direct and emotionally managed manner. The therapist and parents elicit thoughts, feelings, and memories in order to explore every nuance of these experiences.

With the parents, the therapist helps them resist the temptation to gloss over these conflicts, offer solutions too quickly, or become defensive. Instead, the therapist coaches the parents to interview the adolescent and express interest in and curiosity about his or her subjective experience. Parents should remain empathic and supportive. If parents become overbearing or too protective, adolescents may feel infantilized and cut off communication. Respecting the adolescent as mature and autonomous, yet still lovable and in need of support and empathy provides the appropriate balance of nurture and protection that fosters secure attachment. In general, this first phase of the conversation should last as long as possible. Family members may never address these issues again, and parents and adolescents are learning to work through and tolerate emotionally charged, conflict-focused conversations.

In the second phase of this conflict resolution task, the parent is given a chance to express his or her side of the story. Prior to this phase, the therapist delicately blocked the parent's attempts to explain or apologize for his or her past behavior. Once the adolescent's memories, feelings, and attributions have been thoroughly explored, however, the therapist encourages the parent to present his or her own perspective on,
and experience of, the rupture events. Parent's explanations may include descriptions of mitigating circumstances or personal weaknesses. Remorse and contrition are common (e.g., "I was depressed and did the best I could, but I see it was not enough."). The therapist coaches the adolescent to ask difficult questions regarding the parent's behaviors, motives, and regrets. However, the therapist is careful not to let the parent's disclosure invalidate the adolescent's experience or elicit the adolescent's caretaking behavior.

The importance of the parent's disclosure appears counterintuitive, given the focus on the adolescent. Nevertheless, our studies have suggested that a brief and discrete period of parent sharing and vulnerability fosters an atmosphere of reciprocity that promotes the rebuilding of trust and the renewal of an adolescent's desire for closeness. It is as if for a few moments, this conversation is between two mature adults, sharing their own experiences and offering each other understanding and empathy. The adolescent sees his or her parent as an autonomous, distinct person with his or her own strengths, weaknesses, and challenges, rather than simply as the parent who failed him or her. Obviously, too much sharing, or sharing with the intent of defending or guilt inducing, is inappropriate. The therapist must watch, listen closely, and be ready to redirect the conversation if these negative directions begin to appear. The therapist should help the adolescent appreciate his or her parent's perspective, yet restrain the adolescent from overprotecting the parent or becoming parentified.

The adolescent and parent disclosure phase lays the foundation for a more mutual dialogue and developmentally appropriate family interaction. The parent, aided by the therapist, invites the adolescent to explore his or her own reactions to the parent's
disclosure. Often the parent's explanation and apology can stir up deeper and more vulnerable emotions for the adolescent (e.g., sadness or remorse). The therapist helps the adolescent explore and accept "mixed" feelings (e.g., empathy and resentment) towards his or her parent and struggles with whether, when, and how to forgive the parent.

At the end of the conversation, the therapist compliments the family for sustaining such an intense, honest, and revealing conversation. Rather than encouraging the family to summarize or draw conclusions (i.e., intellectualize) about the session, the therapist punctuates the integrity shown by each family member during the conversation, as well as the collective mood of intimacy and accomplishment.

Critical to the success of the session is the therapist's own presence and state of mind: focused, intense and affectively attuned. The therapist must follow every nuance of conversation in order to keep the family on track and find doorways that lead to deeper and more profound and honest communication. The therapist's vision keeps the conversation meaningful, fluid, and often unexpected. The therapist must expect and extract the best from each family member, orchestrating a melody of honesty, grief, self-reflection, and humility. When therapist themselves are in this "zone", families are much more likely to follow.

Task Five: Promoting Competency

The fifth treatment task focuses on promoting the adolescent's perceived and actual competency. The three primary goals of this task are to (a) increase the quantity and quality of competency experiences, (b) decrease social isolation, and (c) help
parents become an effective resource for the adolescent. During this task, the therapist increases his or her attention to behavioral and organizational changes, both inside and outside of the home. These behavioral changes are supported by the interpersonal strengths and skills developed in the first half of treatment. In fact, solving current behavioral problems becomes an exercise in using the newly found trust and mutual respect experienced in earlier sessions. In particular, the therapist now encourages parents to appropriately challenge and support the adolescent to become more motivated and courageous. Similarly, the therapist encourages the adolescent to stop blaming his or her parents, take his or her life more seriously, and accept greater responsibility for his or her behavior. In these sessions, family members thereby practice and solidify their new interpersonal skills, competencies, maturity, and trust while working through the more concrete behavioral problems of life. Therefore, this task requires the therapist to keep his or her eye on both interpersonal processes (e.g., how family members talk to each other) and behavioral goals (e.g., returning to school).

The therapist encourages the family to discuss and develop expectations about normative activities such as chores, curfews, dating, and allowance, as well as problems related to school, peers, violence, drugs, relationships, and sex. Parents are encouraged to support the adolescent's small steps toward autonomy and competency (e.g., new clothes, hairstyles, make-up, ear piercing, etc.). Since depressed adolescents are often out-of-step with their peer group, supporting age-appropriate behavior can help them feel more adjusted. Within limits, the therapist encourages parents to show interest in the adolescent's activities without being over-involved or controlling (i.e., adolescent teaches parent about rock and roll music). Simultaneously, parents must
become less tentative about setting appropriate goals and expectations. Without expectations, adolescents have no standards or vision (Baumrind, 1991). But the expectations need to be realistic. For some adolescents, remaining in an honors program or even finishing school may be a self-defeating goal. Ideally, the adolescent should be involved in the negotiation of these decisions and plans. This enhances confidence, communication skills, and a sense of agency.

An important step in promoting competency is to increase or improve the quality of the adolescent’s (and parents’) connections to social supports or resources. Especially in the context of a brief treatment, therapists must make immediate contact (often within the first week) with important extended family members, school personnel, and social service providers (e.g., probation officers and social workers). These support systems provide a broader, ecological context to the family and assist in identifying important treatment goals. The therapist may invite important persons to attend a session, go on a home or school visit, or keep other professionals updated by phone. Whenever possible, adolescents and parents should participate in planning these larger systems interventions. Adolescents should take an active role in these events and not be a bystander. Parents should advocate for their adolescent while continuing to appropriately challenge him or her.

We have begun integrating Cognitive-Behavioral Therapy (CBT) into the ABFT framework (see anxiety treatment below). Thus far, CBT has been used after the initial goals of the family treatment are accomplished. This sequence diffuses family tension and builds family trust. Once secure attachment is on the mend, CBT skills can be taught without the family conflict spoiling the learning environment.
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Empirical Support

ABFT has garnered empirical support from clinical and process research studies. In the first outcome study (Diamond, et al., 2002), funded by NIMH, 32 adolescents were randomized to 12 weeks of treatment or a six-week waitlist control. Of the 16 treatment cases, 13 (81%) no longer met criteria for MDD post treatment, while only 9 (56%) of the patients on the waiting list no longer met criteria for MDD post-waitlist ($X^2[1]=4.05, p < .04$). Clinical improvement was also significantly better in the treatment group where 62% of the adolescents treated with ABFT had a BDI of 9 or less compared to 19% of adolescents in the waitlist condition (BDI < 9, $X^2[1]=6.37, p = .01$). Patients treated with ABFT also showed more improvement on anxiety, family conflict, attachment to mothers, hopelessness, and suicidal ideation. Similar results were maintained at 6 months. In addition, several process research studies have also been carried out that explore the specific processed and proposed mechanism of each ABFT task (see Diamond, Siqueland & Diamond, 2003). Although this first study is small, it is promising and warrants more research.

Three new studies are currently underway. One study focuses on suicidal adolescents presenting in a primary care setting. This study aims to integrate a brief (6 week) ABFT model into the primary care setting. A second study provides brief family treatment in combination with anti-psychotic medication for adolescents with psychotic depression. Finally, we are developing an ABFT psychoeducational parenting program to be used with children of depressed parents in community mental health settings. These studies will help broaden the application of ABFT to other populations and provide more empirical support for its effectiveness.
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ABFT for Anxious Adolescents (ABFT-A)

We have begun to adapt ABFT to working with anxious adolescents (Siqveland, Rynn, Diamond, in-press). This approach combines ABFT with individual cognitive-behavioral treatment. Although the basic structure of the five tasks is retained, some modifications are made to the clinical model. ABFT-A targets four primary processes: parental beliefs about anxiety, family modeling of anxious behavior, encouragement of avoidance, and psychological control related to communication and negotiation of conflict. Overall, family treatment focuses on autonomy granting as the central challenge to the parents and adolescents. These targets are explained in brief below.

In families with an anxious child, family beliefs about parenting and anxiety can seriously impact the adolescent’s ability to cope with life challenges. Many parents view anxiety as threatening and something to be avoided at all costs. Consequently, they strive to protect their adolescent (and themselves) from these experiences. This leads to parenting behaviors that promote avoidance and dependency. Possibly more subtle is the parent’s use of psychological control. Here, parents discourage different viewpoints, feelings, and experiences within the family, especially regarding negative affect (e.g., anger and sadness). These families often believe that the expression of differences or conflict will damage, or lead to, the loss of their intimate relationships. Therefore, open negotiation of conflict is blocked, which derails the normative task of autonomy development. These dynamics reinforce adolescents' dependency on parents, which reinforces a self-concept of incompetence. Unfortunately, anxious adolescents have become so dependent on parents that they contribute to the maintenance of these dynamics as much as the parents.
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In our first pilot study with this population, families received an initial family session to help set the stage for therapy (Siqueland, Rynn, & Diamond, in-press). How does the family feel about and handle the adolescent's anxious behavior, and can they be a better resource to the adolescent as he or she attempts to reduce or overcome these problems? Session two is an alliance-building session with the adolescent alone. After the general bonding phase, the therapist explores individual desires, fears, and barriers about autonomy. Family issues usually revolve around adolescents' concerns about protecting or upsetting their parents, discomfort with conflict, or feeling their parents do not understand them. This alliance-building/problem identification session is followed by 3-4 individual CBT skill sessions.

The alliance-building session with the parents alone occurs some time during the CBT sessions with the adolescent. The session focuses on identifying parents' own anxiety and fears and how these worries might lead to parents restricting the adolescent's autonomy and encouraging his or her avoidance. The therapist helps the parents re-examine their view of the adolescent as frail, and he or she challenges parents' tendency to protect the adolescent from danger and encourage him or her to avoid challenges. The therapist helps parents understand that promoting psychological autonomy means encouraging the adolescent to express opinions, differences or conflicts and learn to rely on him- or herself for self-soothing and coping.

The remaining 8 or so sessions involves combinations of parent-adolescent, adolescent alone or parent alone sessions as determined by the particular case. The sessions focus on the CBT, exposure therapy, and family themes identified in individual adolescent and parent sessions. Discussions can directly address family beliefs or

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focus on current problems; both provide opportunities to alter interactional patterns that reinforce psychological control and restrain autonomy building.

Parents are also included in in-vivo exposure exercise, where they are coached to provide support while promoting the adolescent's independence in the task. In this way, CBT training not only serves to build skills to buffer anxiety, but it also offers an additional context for prompting parent support and protection of the adolescent.

An initial open pilot study was conducted with 8 families receiving ABFT-A (with the CBT sessions). This pilot allowed us to refine the treatment manual and carry out an initial test of the approach. The results show significant change over time with a majority of patients reporting Hamilton Anxiety (88% < 12) and BAI scores (88% < 18) in the non-clinical range. We then conducted a randomized pilot trial with 11 families receiving either ABFT-A or CBT alone. Ninety-one percent completed 12 of the 16 sessions and 55% completed the full 16 sessions. There were no significant treatment differences on diagnosis or anxiety or depression rating scales at post-treatment or 6 months follow-up. There was a trend finding for adolescents' report of psychological control post treatment (F(1, 11) = 2.2, p = .18), with adolescents in CBT reporting an increase in psychological control and adolescents in ABFT-A reporting a decrease in psychological control.

The lack of difference in these preliminary findings is not surprising given the small sample size. But the main goals of a treatment development project such as this is model development, testing feasibility, acceptability, and gathering pilot data. On these fronts, the project has been successful and we are pursuing funding for a larger study to more fully test effectiveness of ABFT for this population.
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Low income, minority patients

Much of the treatment development work of ABFT has been with inner city, often African American families. Therefore, many clinical features have been designed to meet the needs of this population. First, ABFT focuses on trauma and loss, extremely common experiences for inner-city populations. The inner city has been called a war zone, where most children are exposed to, witness, or experience loss due to violence (Garbarino, Kostelný, & Dubrow, 1991). However, youth and families often identify them as critical events, which can exacerbate underlying psychiatric conditions. Second, the ABFT therapist focuses heavily on engagement and reduction of treatment barriers. Lack of mental health insurance, financial constraints, stigma regarding mental health, and mistrust of “systems” have been noted as barriers to mental health service for African Americans (U.S. DHHS, 2001). We address these barriers not only logistically (e.g., phone calls, occasional home visit, bus tokens, child care, etc.) but explicitly develop trust and respect. Third, this population is likely to experience adversity and hardships, have limited resources, live in chaotic neighborhoods, and experience societal oppression. Consequently, ABFT therapists are selective, but ecologically oriented in their case conceptualization and treatment plan. Contact with schools, social service providers, probation officers, neighbors, and extended family members are necessary activities when working with poor urban families.

Fourth, treatment themes focus on several topic areas that are salient when working with this population. These topics include racism, skin color, loss of fathers, community violence, religion, teen pregnancy, and drug use. In addition, guidelines are given about cultural etiquette (e.g., using last names, respecting the role of elders, and

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encouraging families to discuss racial difference between themselves and the therapist, if necessary). Finally, ABFT's emphasis on brief treatment with specific problem focus is culturally congruent with African Americans who tend to prefer an action-oriented therapeutic approach with short-term goals (Sue & Sue, 1999).

Case Vignette

A brief summary of the case described at the beginning of the chapters exemplifies how ABFT unfolds over the early phase of treatment. As described, in the first session, with some elicitation of vulnerable emotions, Sally (the daughter) expressed her feelings of rejection and abandonment by her mom and her memories of an abusive father, which her mother had minimized and discounted. In the second session, the therapist met alone with Sally. After discussions of her interest in music and art, the conversation turned to her relationship with her mother. Sally returned to her initial protest that she was no longer interested in being close to her. The mother was too strict, only concerned about her schoolwork, and seemed uninterested in helping with her life challenges (depression, boys, alienation from friends). The therapist reminded the daughter of her tears from the last session and wondered what happened to her feelings of loneliness and the deep desire for mom's love. Sally continued to protest until the topic of the father resurfaced.

A long conversation ensued that depicted deep ambivalence about her father. On the one hand, she was dad's favorite and she loved the attention. On the other hand, once his depression had set in, she despised his irritability, drinking, and abusive behavior towards her mother. When asked how often she had discussed these events
with her mother, Sally reported that mom had made this topic off-limits. Then, in loyalty to her mother, Sally said she agreed with her mother that these events were better forgotten and "we should just try to get on with our lives." But the therapist was empathically steadfast, saying, "Your memories of him are your life. He is in your music, your art, and your fears of being bi-polar like him. His ghost lives with you every day." The therapist did not believe that exorcising dad’s ghost was the key to Sally’s recovery. But he did believe the denial or avoidance of these feelings and events by the family was indicative of the emotionally constraining climate in this family. After some more tears, Sally agreed that discussing these issues with mom might have some value.

In the following session, the therapist met alone with the mother. Initially, the mother was surprisingly guarded and gave brief answers to the therapist's empathic inquiries about her life. Eventually, the therapist commented about the tension in this conversation, saying, "You know, you seem less trusting of me today. Have I done something to upset you?" After some discussion of this, the mother revealed that she worried that the therapist was looking for evidence of her bad parenting in order to take her daughter away from her. The therapist’s shock at this seemingly irrational fear dissipated as the mother began to tell her childhood history.

Her depressive mother (grandmother) left the family with a lover when she was 10 years old. This put her in charge of the other four children and an alcoholic father. When dad made sexual advances toward her at the age of 16, she left home and never spoke to her father again. She spent the next five years in fear of getting arrested and sent home, but by the age of 21 she got herself into college, eventually became a computer programmer, and was now the director of a larger data management service.
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at a local hospital. The therapist expressed admiration for her tenacity and resilience, and also empathy for the loneliness of her "don't look back" approach towards life. What had allowed her to survive came with the price of emotional isolation. While the mother fought back tears, the therapist offered her the opportunity to protect her daughter from a similar fate. The therapist said, "You know what it is like to be abandoned by a parent, to be so cut off that you have no one to turn to or trust... Your daughter needs you. She wants to feel she can come to you for help and support." In this vulnerable state, the mother could appreciate the therapist's intent. But still she feared that she could not provide the kind of emotional attention that her daughter craved. The therapist offered to meet alone with the mother again to discuss the basic skills of emotional coaching.

When Sally and her mother came back together, they were both cautious. However, with the therapist's gentle guidance, the daughter initiated a conversation about her father. Knowing very little about her father, Sally began by asking questions about his work and hobbies and eventually about his depression. She asked about his history of depression and the aneurysm that killed him, and she shared her fear of being bi-polar like him. The mother compassionately offered any information she could. Then Sally began to talk about her ambivalence towards him, both loving and hating him. She started to cry when she shared her guilt over wanting him dead, as if that had killed him. In response, mother moved next to her daughter, held her, and said soothing statements as she stroked her hair. Sally willingly gave in to her mother's comfort and continued to cry for several minutes. The issues with her father were far from resolved, but a breakthrough had occurred in Sally's tolerance for emotional distress and a mutual trust between her and her mother.

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The next several sessions continued to focus on family history. But gradually, Sally and her mother were becoming better friends. As Sally gained insight about her mother's relational and emotional history, she felt less compelled to blame her and more accepting of her emotional constriction. As Sally acted more maturely in the session, mother came to appreciate that her little girl was an emerging woman. This led to more mature negotiations about expectations in the home and privileges outside the home. Mother offered Sally the guitar lessons she had denied her. (Mom survived as a musician in her adolescent years and had not wanted that life for her daughter.) Treatment reduced to every other week for six more months. The family had several crises along the way, and Sally's depression had similar cycles. New medications were tried with varying responses. Sally ended her long-distance phone relationship of one year, because she now felt ready for a more substantial connection with someone. As the treatment ended, she had fallen in love with a new boy (one mom approved of) and was the singer in a punk rock garage band (which mom reluctantly supported). Occasionally, the therapist received emails from Sally with a few pictures or a new poem or song. Sally went off medication and was doing fine with a few low periods. A year later, the family came back over a crisis in school. The therapist helped them get back on the same team, and the family resolved the school issue on their own.
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