Attachment Based Family Therapy: A New Approach to treating depressed, suicidal and traumatized youth

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Pravin Israel & Magnus Ringborg
Dr. Psychol/ Psykologspesialist Leg Psykolog, Leg Psykoterapeut
Plan for the symposium

What is ABFT?
What ABFT is not
Theories behind ABFT
The clinical Model
Empirical support & training
Questions / comments
Core content: Family relationships
How common is depression in adolescents?

- 2.5% - 4% in general population
- 11.4% lifetime estimate
- 61% in psychiatric population
- Adolescents in Norway (16 år)
  - 9% (♀)
  - 3.2% (♂)
- **Internasjonally**
  - 3ed largest cause for mortality among 10-19 year olds
  - 1 of 5 adolescents consider suicide
  - 5-8% have attempted suicide

- **In Norway**
  - About 69 young people (15-24 år) commit suicide every year
  - 30% have suicidal ideation
  - 10% girls and 6% boys have attempted suicide
Why family therapy?

Core content: Family relationships
What is ABFT?
Empirically supported treatment

- Short-term (12-16 weeks)
- Semi-structured manual
- Task based clinical model
- Promising empirical support

Theoretical foundations

- Interpersonal theories (Sullivan, Coyne, Joiner)
- Structural Family Therapy
  - In-vivo, experiential, enactments
- Attachment theory
  - Adolescent attachment
  - Goal is to re-establish normative attachment eg., security, protection & availability
Attachment theory
Attachment in adolescence (12-17 years)

Balance between autonomy and affiliation (attachment)

Me
Mama
You/the world
AAI-Earned Security

Help youth identify and crystalize content and affect that has been avoided

Receive validation and new information regarding the past and present experiences

Youth assimilate new and coherent view of self and others
Adolescent Development

Normative development

- Takes place in the context of loving and caring context
- Sometimes there are frustrations and tensions

Parent-youth relationship

- The goal is transformation NOT separation
- A stable and secure relationship is essential
How is Attachment negotiated in adolescence?

From behavioral control to conversation and cooperation

Conversation is the most important tool

What are important attachment tools?
- Trust/respect
- Parental support and availability
The Clinical Model (PRAVIN)

The Clinical Model (PRAVIN)

Israel & Diamond, 2009

1. Relational Reframe

Task 1

- Orienting to the session
- Relating to the problem

Task 2

- Establishing bonds with the adolescent
- Adolescent’s goals for therapy

Task 3

- Establishing bonds with the parents
- Parents’ goals for therapy

Task 4

- Adolescent-Parent dialog
- Adolescent’s complaints
- Parents’ short statement

Task 5

- Promote competency
- Help foster parent as a resource
- Increase meaningful experience
- Reduce social isolation

Task 6

- Bring from relational problem
- Redefine relational problem
- Define the problem
- Relate to the problem

1. Ongoing process
2. Relational redefining
3. Relational redefining
4. Orientation to the session
5. Relating to the problem
6. Establishing bonds with the adolescent
7. Adolescent’s goals for therapy
8. Establishing bonds with the parents
9. Parents’ goals for therapy
10. Adolescent-Parent dialog
11. Adolescent’s complaints
12. Parents’ short statement
13. Promote competency
14. Help foster parent as a resource
15. Increase meaningful experience
16. Reduce social isolation
17. Bring from relational problem
18. Redefine relational problem
19. Define the problem
20. Relate to the problem

The Clinical Model (PRAVIN)

Israel & Diamond, 2009
What ABFT is not

- Some theoretical notes
• ABFT is not a client-centered therapy
  • But it is client-respectful
  • The therapist leads the process
ABFT is not solution focused

• The therapist does not jump to exceptions
• Instead she tries to hold on to the vulnerable feelings
ABFT is not a cognitive therapy

• The therapist focuses on relational affects.
• When family members reflect, the therapist asks how they feel
ABFT is not a problem solving therapy

- In the initial tasks, problem solving is seen as an escape from getting into the deeper vulnerable feelings.
- Problem solving within the family comes as a natural part in Task 5.
ABFT is not a behavior therapy

- The adolescent is not coached to behavior activation by the therapist
- In task 5, parents and other family members are natural coaches for the adolescent
- But, especially in Task 4, family members are exposed to prolonged experience of avoided affects
ABFT is not a psychodynamic therapy

• The restructuring of affects and attachment are not changed via a representative, the therapist, as in psychodynamic therapy

• But directly with the attachment person
ABFT is not “individual therapy”

• There might be more than one session in each of Task 2 and 3, but they are not ”individual therapy”

• Their function is to serve as preparation for the central Task 4, reattachment
ABFT is not structural family therapy

- Well, it is from Philadelphia, and enactment plays a central role, but
- while structural family therapy is a general model,
- ABFT is a slower, manualised step-by-step-model that is carefully adapted for a few specialised clinical problems
ABFT is not narrative, nor language systemic

• You tell stories also in ABFT, but the therapist is not an editor of standardised hero tales
• The therapist is of course careful with words, but tries to work with affects more directly in the session
Task 1: Relational Reframe

**New content**
- Shift from the patient as the problem to the family relationship as the solution

**New affect**
- From blame & anger to longing & empathy

**New expectations**
- All family members take responsibility for change

Shift from patient as the problem to family relationships as the solution
Task 1: Relational Reframe

1. Introduction to the session
2. Bring forth problem definition
3. Relational reframe
4. Establish treatment contract
Task #2: Alliance Building with the Adolescent Alone
Three Phases of Adolescent Alone Session

1. Bonds – Client moves from suspicion to comfort

2. Goals – Identify meaningful goals for the adolescent. Link problems to family relationships.

3. Tasks – Prepare the adolescent to what the re-attachment task will look like.
Find the core attachment ruptures

- "How come, when you feel suicidal or want to hurt yourself, how come you don’t go to your mother?"
- "What is the obstacle between you?"
- "When did you stop trusting her?"
- "What happened?"
- "How did you feel?"
Anchor in Affect

- Find one good paradigmatic story
- Elaborate enough detail to evoke strong memories
- Identify core emotions experienced at that time
- Use strong emotional language: lonely, abandoned, sad, scared.
Getting the Sign on

- "If I could get them to listen, would you be willing to tell them?"
- Therapist helps adolescent prepare what they want to say.
- Therapist helps the adolescent explore their potential emotional reaction.
- Help the adolescent process their old: "Was that an effective strategy?"
- Discussion of feared reactions.
Working with Resistance

- If the adolescent is concerned about burdening their parent:
  - These things are killing you, they are driving you to self-destruction, you deserve to be heard.
  - What you are doing is causing your parents more pain. Your parent will grieve for the rest of his/her life if you take yours.

- If the adolescent worries that her parent won’t listen:
  - You’ve never tried it with me. I can make it different. I can make them listen. I will protect you.
Task #3: Alliance Building with the Parent
THREE PHASES OF PARENT SESSION

1. Bonds
   • Current Stressors
   • Intergenerational Exploration

2. Goals
   Parental commitment to be there for their adolescent in a different way

3. Tasks
   • Preparation for reattachment conversation
   • Teaching parents Emotion Coaching
1. Build alliance with parent
   - have parent feel appreciated
   - have parent see therapist as a resource
   - assure parent will not be blamed

2. Look for obstacles that inhibit relationship building

3. Look for strengths that facilitate relationship building
Exploring Current Stressors

- Explore impact of parent’s personal stress on their parenting practices
- Reduce parent blame and guilt by putting parent-adolescent conflicts into context.
“How do you think these things have impacted your parenting?”
“It must be hard raising an adolescent, let alone a depressed one, when you have so many other stressors in your life.”
“Wow, you are dealing with all this and your son. No wonder you are not being the kind of parent you want to be.”
Exploring Childhood Attachment

- Tell me about your childhood.
- Were you close to your parents?
- Could you go to them when you were having problems?
- What got in the way?
- How did that make you feel?
- Did you have any one to turn to?
Anchor the story in Affect

- Find one good paradigmatic story
- Elaborate enough detail to evoke strong memories
- Identify core emotions experienced at that time
- Use strong emotional language: lonely, abandoned, sad, scared.
“Sounds like you experienced some of the same things your adolescent is talking about now. You two have some common experiences.”

“Would you be interested in protecting your adolescent from some of the same pain that you experienced as a child?”

“Would you like to be the one to interrupt this multiple generation of pain and abuse?”

“I can help you be there for your adolescent in ways your mom wasn’t there for you. Would you be interested in that?”
Contract for engaging in reparative conversations

- The therapist asks parents if they are willing to engage in the reattachment task.
- The therapist stays with the theme of commitment until the parent has made explicit their agreement.
TASK: Preparing the Parent for the Conversation

TYPICAL QUESTIONS:
- How do conversations usually go for the two of you?
- What would be some of the challenges for you in having this conversation?
- What might go wrong?
- What if your daughter makes you angry or hurts your feelings?

THERAPIST SUPPORT:
- I’ll be there to help
- I will keep us focused.
- I have talked to her and I think she is ready to share some things.
Emotion Coaching
The Five Steps

1. Being aware of child’s emotions
2. Recognize emotion as chance to get closer and to teach
3. Listening empathetically and validating child’s feelings
4. Helping child verbally label emotions
5. Begin problem-solving only after child feels understood
Task 4: Reattachment Task

Goals: facilitate discussion about core attachment ruptures

Process: Enactment

• Adolescent uses new affect regulation and interpersonal problem solving skills; parents use more emotional coaching.
Enactments

In-vivo, experiential, real time conversation between family members

Not teaching or problem-solving

Therapist involvement is minimal

Jump in, help and move out (if you can)

You are the director....forming, shaping, sculpting the content, affect and process
Prolonged emotional states

• Exposure:
  ▫ Adolescents and parents learn to tolerate emotional activation (habituation)
  ▫ They receive new information that challenges fear structures (attributions)

• Affect regulation
  ▫ Family members practice gaining control over emotions that emerge in therapy
Task 4: Reattachment

Both take mutual responsibility for change

Parent(s) listen with respect and support

Adolescent talks about core conflicts
Task 5: Promoting Competency

Goal is to promote competency in:

- Communication skills
- Re-engage adolescents into the social world/activities
- Identify relevant challenges
- Encourage adolescents to make use of their newly acquired “secure base”
- Prepare to terminate therapy
Oppgave 5: Promote competency

- Prepare to conclude therapy
- Help parents become a resource
  - Re-establish parent as secure base
- Increase coping
  - Increase self-esteem as a buffer against stress
- Reduce social isolation
  - Rebuild their social world
Empirical Support

• ABFT has shown to be effective with depressed and or suicidal adolescents in 4 studies.

• Now classified as a proven practice by
  ○ The Rand Corporation
  ○ Soon to be approved by NREPP (National Registry of Evidence-based Programs and Practices)
  ○ Mentioned in the Swedish guidelines
Four outcome studies

Study 1: Open trial (n=15)
- ABFT reduced depression and suicidal ideation

Study 2: RCT (n=32)
- 87% in ABFT recovered (MDD) compared to 47 % in WL (reduction in suicidal ideation & anxiety)
- Increase in family attachment

Study 3: RCT (n=66)
- Suicide behavior (ideation & acts)
- 50% reported sexual abuse; 50% previous attempts
- 30% MDD, 80% Anx; ABFT was better than e-TAU
Sexual abuse and suicidal ideation (Creed et al., under review)

Adolescents that have been sexually abused
- Suicidal ideation
- Suicidal behavior
- Suicidal attempts

Treatment literature
- Less than 10 psychotherapy publications
- Experimental treatment no better than TAU
- Poor response of CBT

Controversies
- SSRI & suicidal ideation
- Poor response CBT + meds
- Family conflicts early in treatment phase
Depression – Sex Abuse

[Graph showing BDI scores over different time points: Baseline, Mid-Point, Endpoint, Follow-up. The graph indicates a decrease in BDI scores over time with error bars showing variability.]
Four outcome studies

Study 4: RCT (n=20)

- Effectiveness study in Stavanger
- ABFT can be taught to clinicians
- ABFT effective in reducing depression
Family Based Treatment of Adolescents with Depression

Stavanger Study

PRINCIPAL INVESTIGATOR:
PRAVIN ISRAEL. DR.PSYCHOL
Resultater (n=20)

Time X Treatment Interaction

HAM-D

BDI-II

Estimated Marginal Means of clinician_rating

Estimated Marginal Means of self_report
Effect size (HAM-D v/12 uker)

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ABFT 1.09

- **Beneficial Effect**
- **No Effect**
- **Detrimental Effect**
ABFT can be taught to Norwegian Therapists

Challenges of supervision

- Clinical model (flat strukture)
- Research model (fidelity)
Videre lesning om ABFT

Tilknytningsbasert familie-terapi for depressert ungdom

Pravin Israel og Guy S. Diamond

Training & Credentialing Process

- Training programs now in Australia, Belgium, Israel, Norway, Sweden, and Virginia
- Clinical training groups in Norway & Sweden
- ABFT Certification – 2 year process
  - 3 Day Introductory Workshop
  - 3 Day Intensive Supervision 3-6 months post initial workshop
  - 90 minute bi-weekly supervision calls for 2 years (52 calls)
  - Therapy tape review with individualized feedback in year 2 (2 tapes/month for 24 total).
  - Certification is valid for 2 years from date of receipt
- ABFT Re-Certification (cost $150/tape)
  - Therapists must submit tapes of each task for review and must meet certification criteria every two years.
Agency and Therapist Requirements

- **Agency**
  - Build a depression/suicide specialty clinic/team
  - Structure to identify appropriate referrals
  - Measurement of Outcomes

- **Therapist**
  - 2 therapists (at least)
    - Therapists have a masters degree and or training in family therapy
  - One clinical supervisor per agency (at least). Provides sustainability
    - Supervisors a required to have a Ph.D. or be an advanced MSW
THANK YOU FOR YOUR ATTENTION

pravin@ahus.no

Magnus-ringborg@branneriet.se