Attachment Based Family Therapy:

A New Approach to treating depressed, suicidal and traumatized youth

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Plan for the symposium

What is ABFT?

What ABFT is not

Theories behind ABFT

The clinical Model

Empirical support & training

Questions /comments

Background

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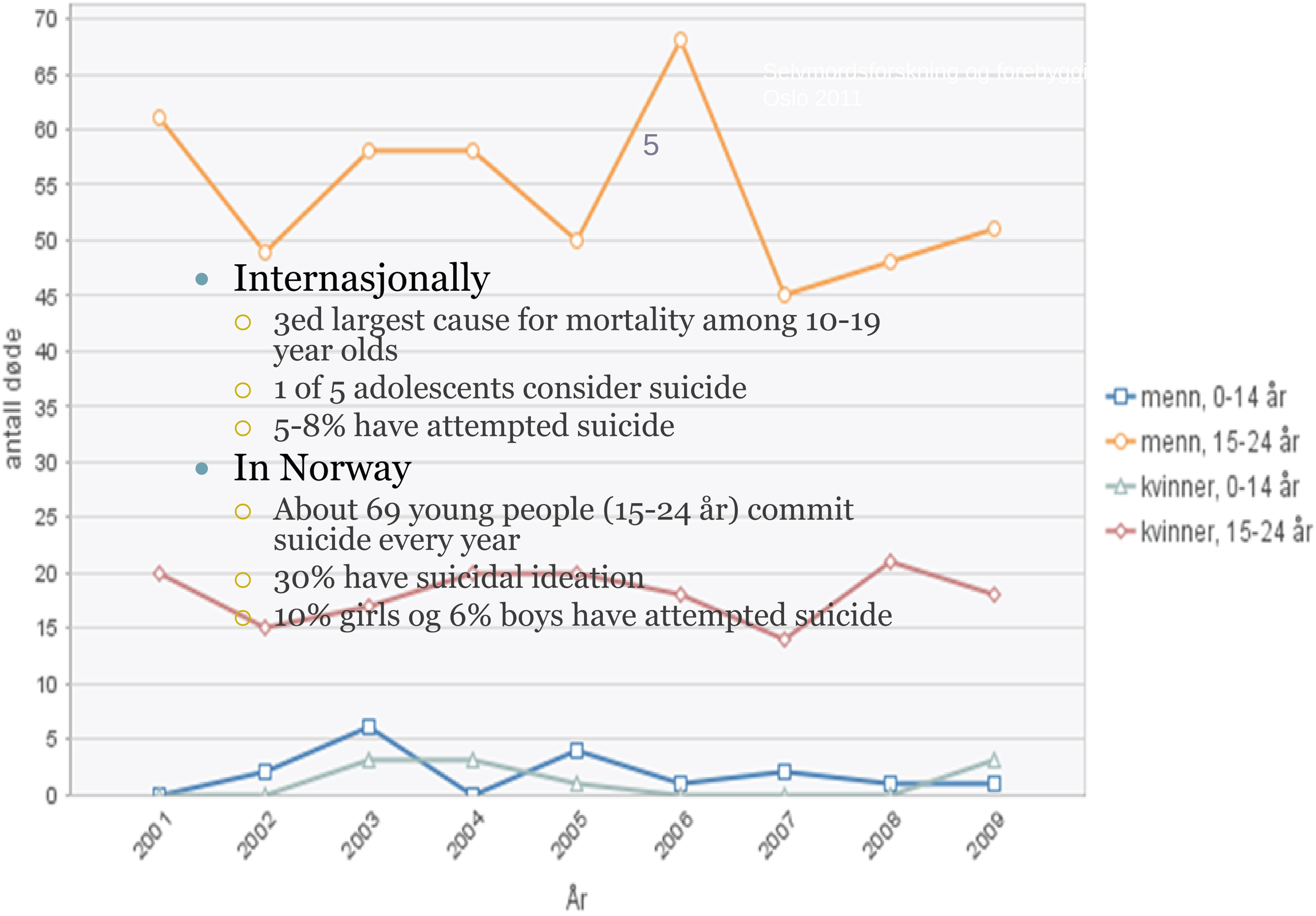
Core content: Family relationships

How common is depression in adolescents?

- 2.5% - 4% in general population
- 11.4% lifetime estimate
- 61% i psychiatic population
- Adolescents in Norway (16 år)
  - 9% 
  - 3.2% 



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- 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 og 6% boys have attempted suicide

Why family therapy?

Core content: Family relationships

What is ABFT?

ATTACHMENT BASED FAMILY THERAPY

Diamond et al., 2002

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

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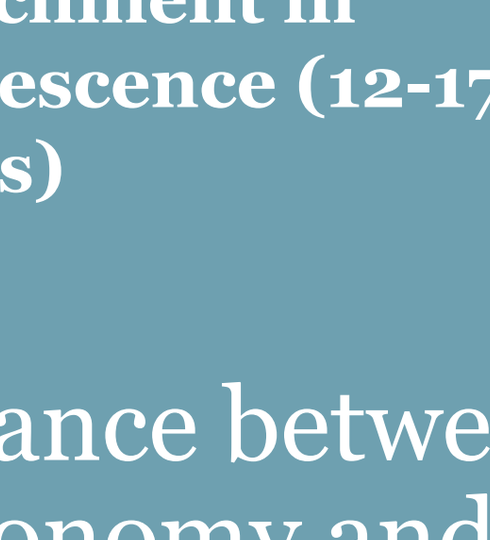
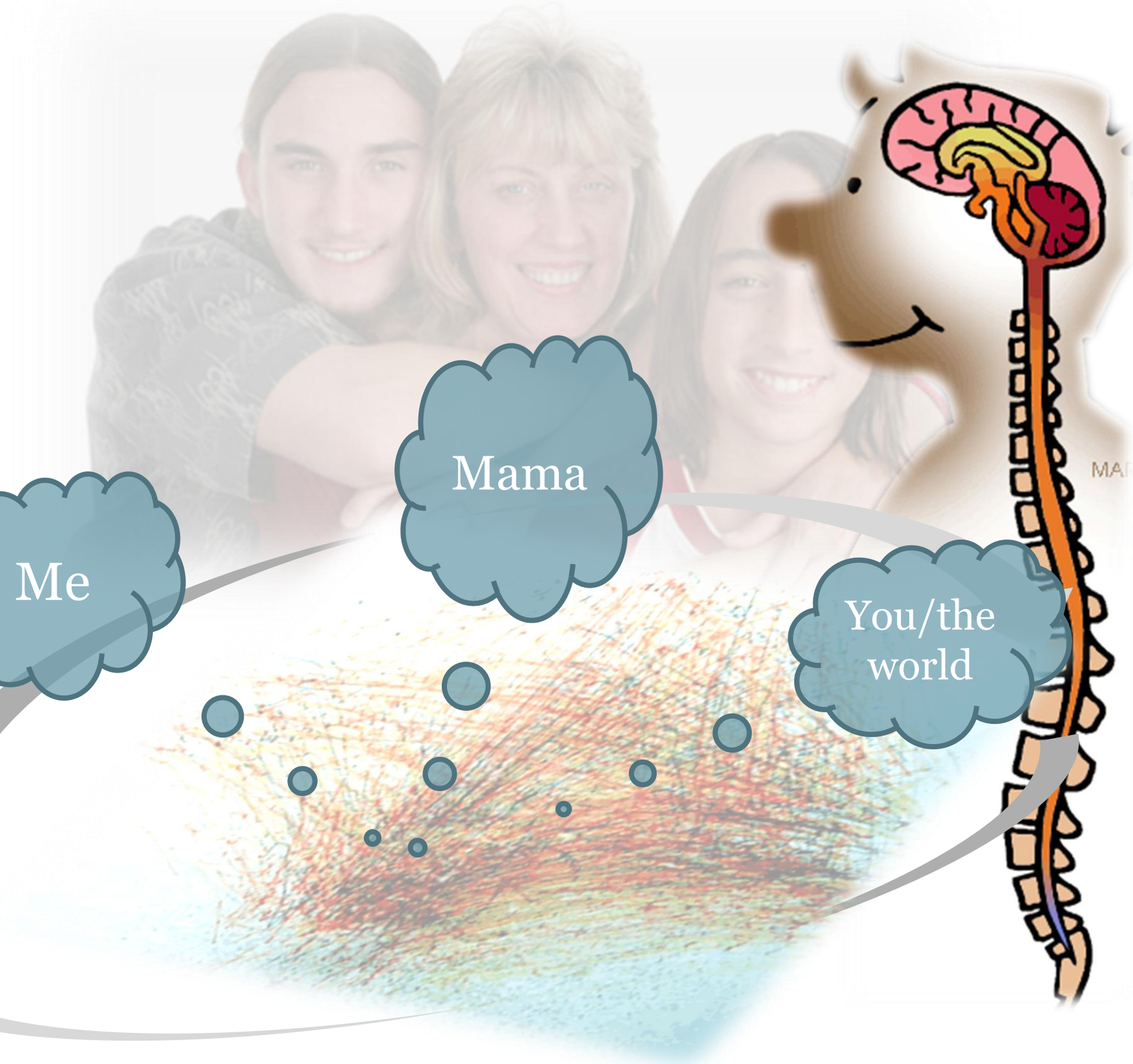
Attachment in adolescence (12-17 years)

Balance between autonomy and affiliation (attachment)





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
- Somethimes 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?

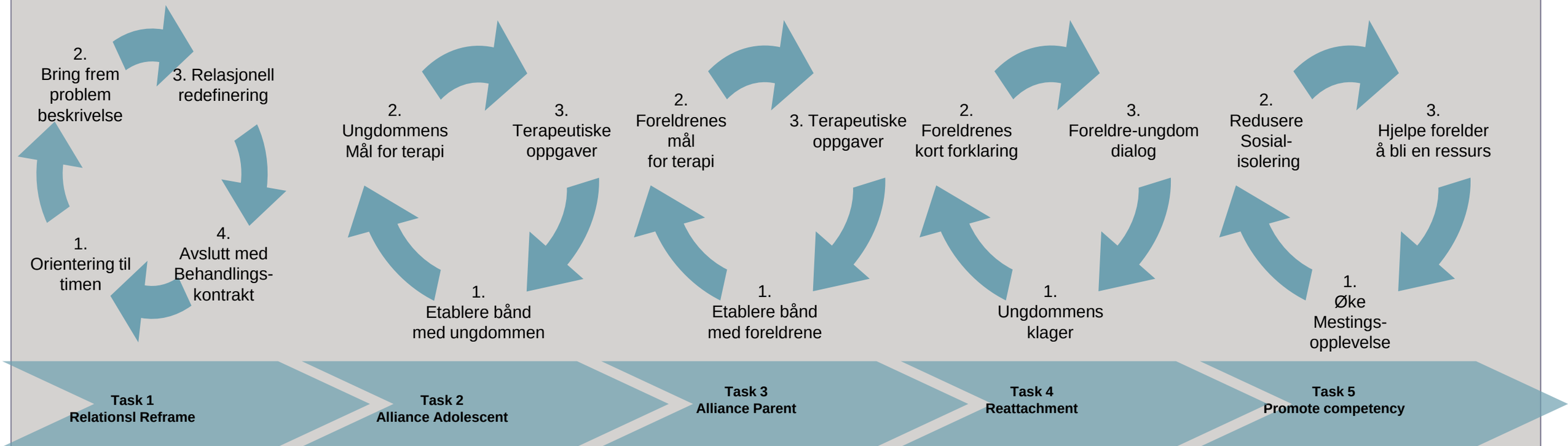
From behavioral control to conversation and coorperation

Conversation is the most important tool

What are important attachment tools?

- Trust/respect
- Parental support and availability

The Clinical Model (PRAVIN)



Israel & Diamond, 2009

What ABFT is not

- Some theoretical notes

- ABFT is not a clientcentered therapy
  - But it is client-respectful
  - The therapist leads the process

ABFT is not solution focused

- The therapist does not jumpt 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 asdolescent
- 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 stuctural 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 affect

- From blame & anger to longing & empathy

New content

- Shift from the patient as the problem to the family relationship as the solution

New expectations

- All family members take responsibility for chance

Shift from patient as the problem to family relationships as the solution

Task 1: Relational Reframe

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?”

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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.

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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 stategy?”
- 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

BONDS

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.

TRANSITIONAL STATEMENTS

- “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.

Transitions

"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

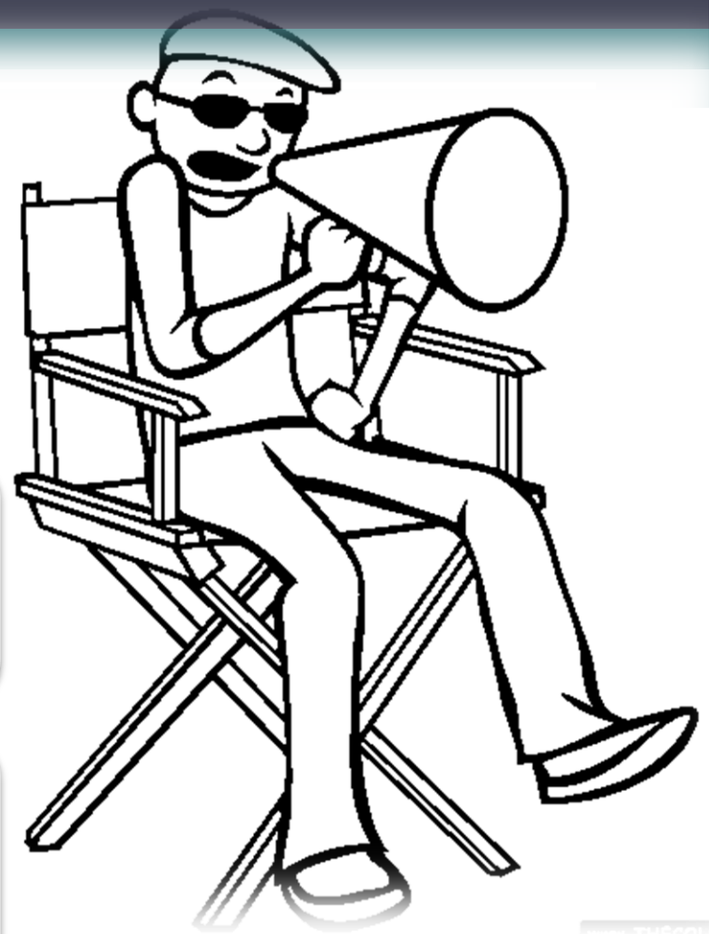
Task 4: Reattachment Task

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

Content

Both take mutual responsibility for change

Affect

Adolescent talks about core conflicts

Parent(s) listen with respect and support

Process

Task 5: Promoting Competancy

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

Increase coping

Increase self-esteem as s buffer against stress

Help parents become a resource

- **Re-establish parent as secure base**

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
  - http://www.promisingpractices.net/program.asp?programid=274
  - 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 suicidalitet (Creed et al., under review)

Adolescents that have been sexually abused

- Sucicidal ideation
- Suicidal behavior
- Suicidal attempts

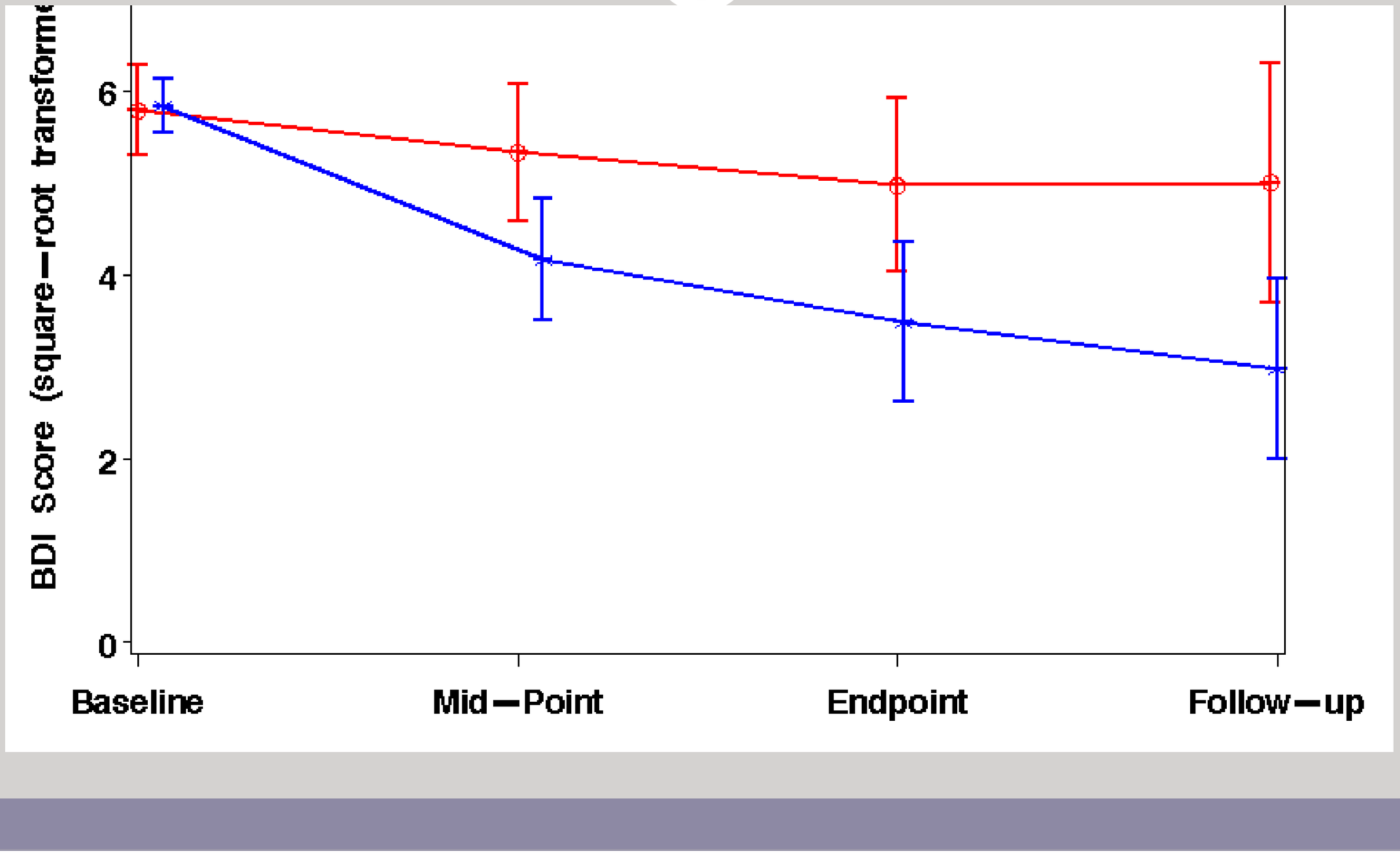
Treatment literature

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

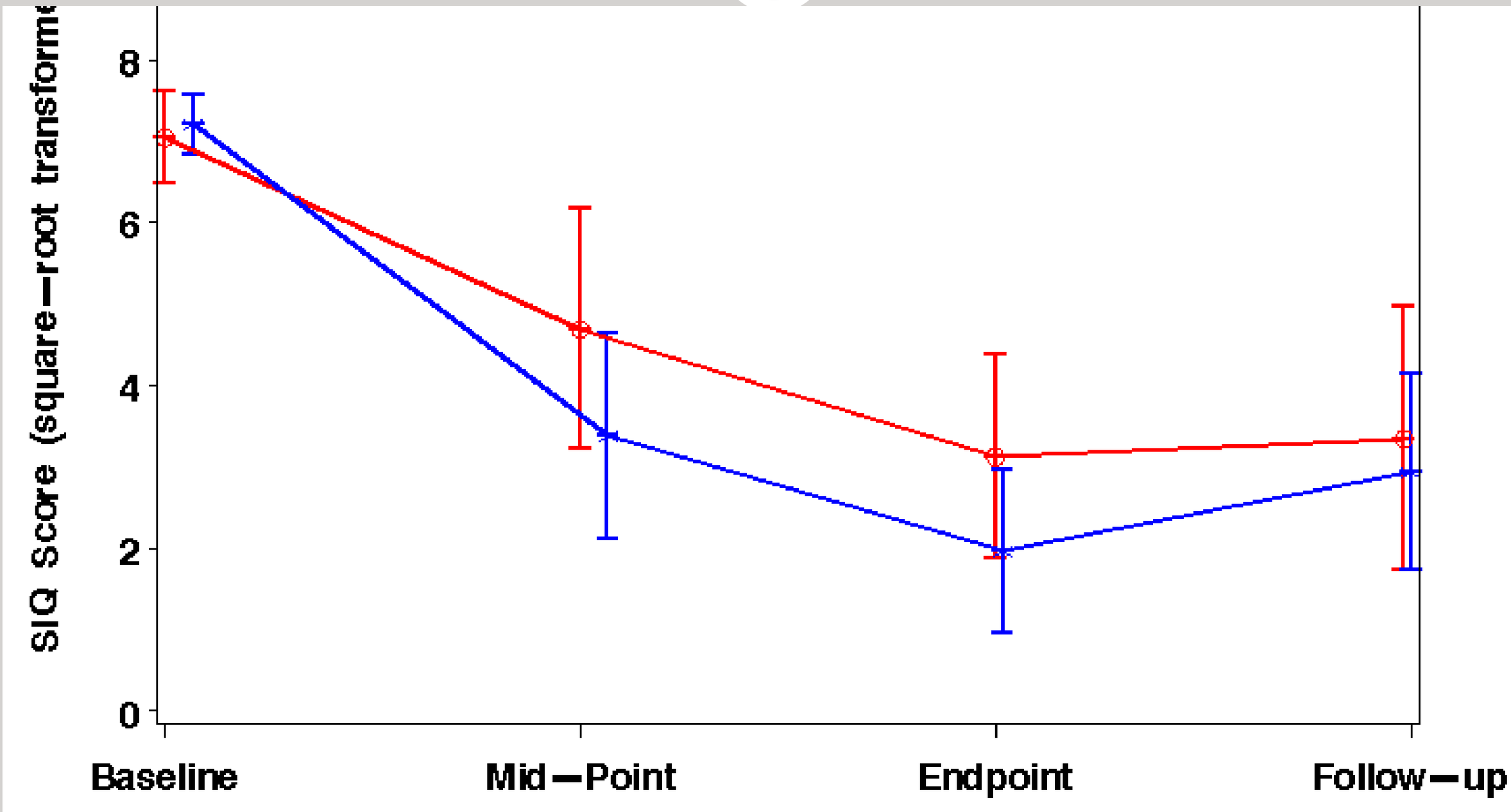
Controversies

- SSRI & suicidal ideation
- Poor response CBT + meds
- Family conflicts early in treatment phase

Depression – Sex Abuse



Suicide Ideation – Sex Abuse



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

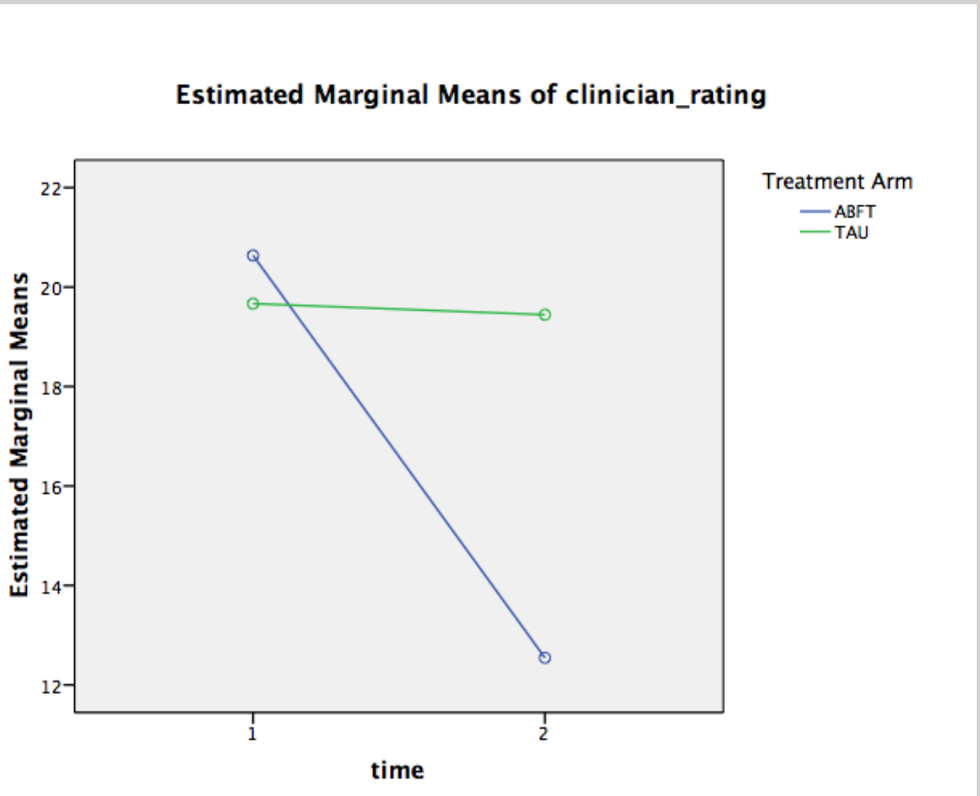
PRINCIPAL INVESTIGATOR:
PRAVIN ISRAEL. DR.PSYCHOL

Stavanger Universitetssjukehus
Helse Stavanger HF

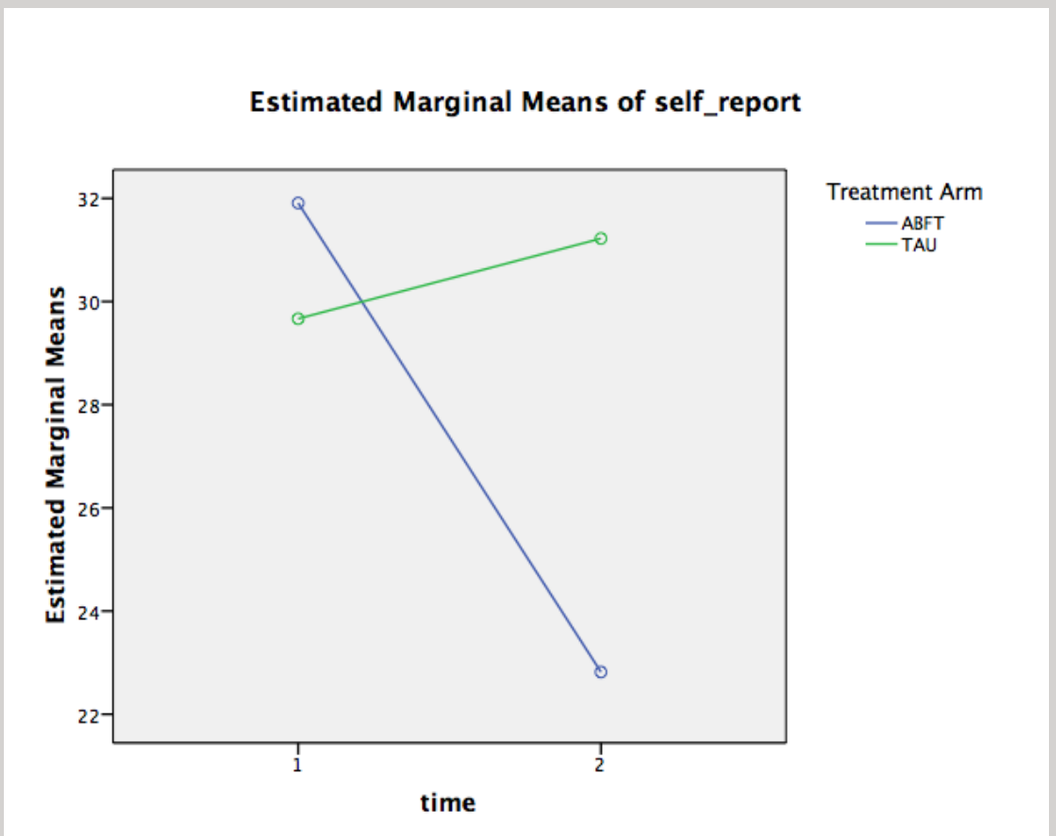
Resultater (n=20)

Time X Treatment Interaction

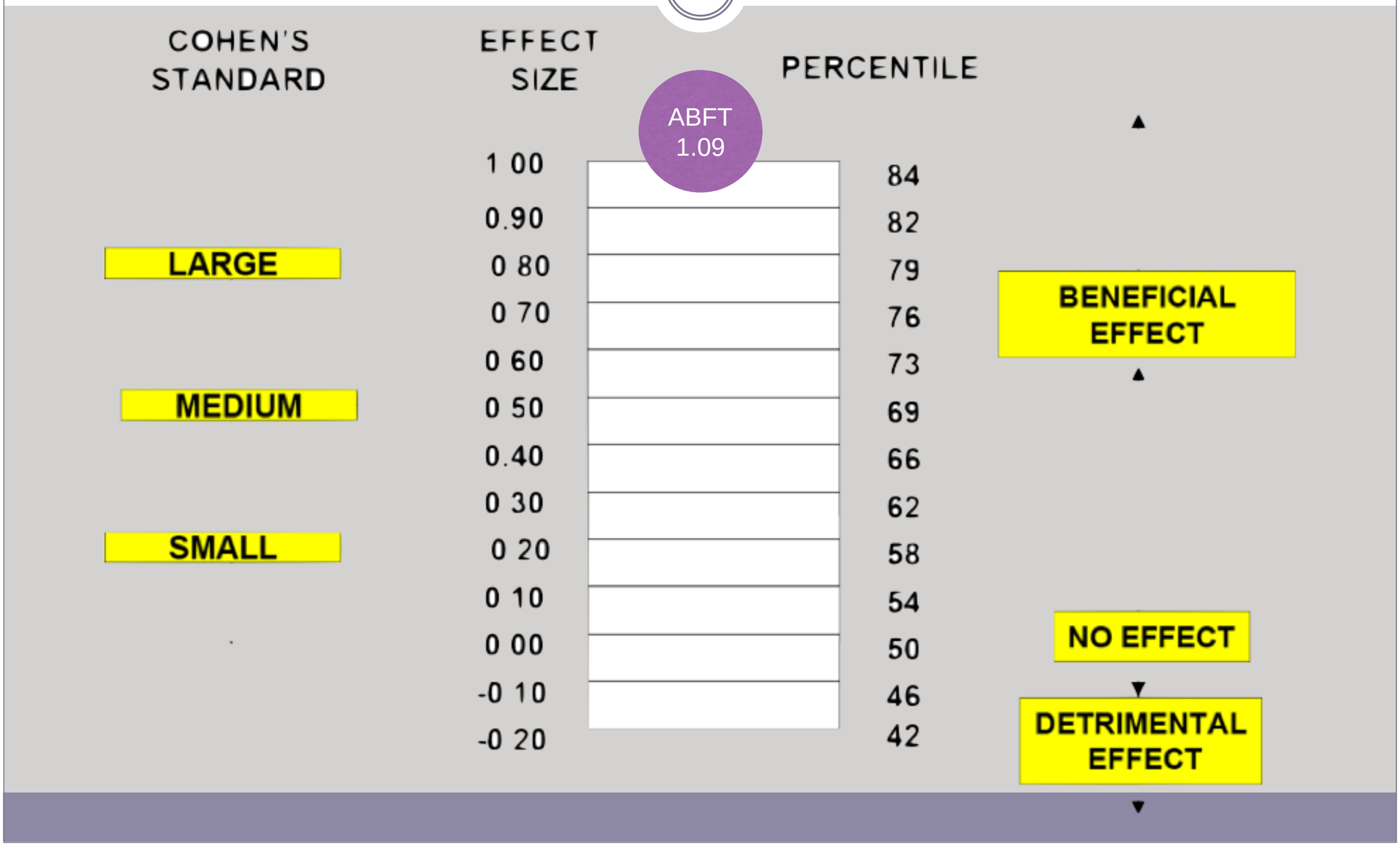
HAM-D



BDI-II



Effect size (HAM-D v/12 uker)

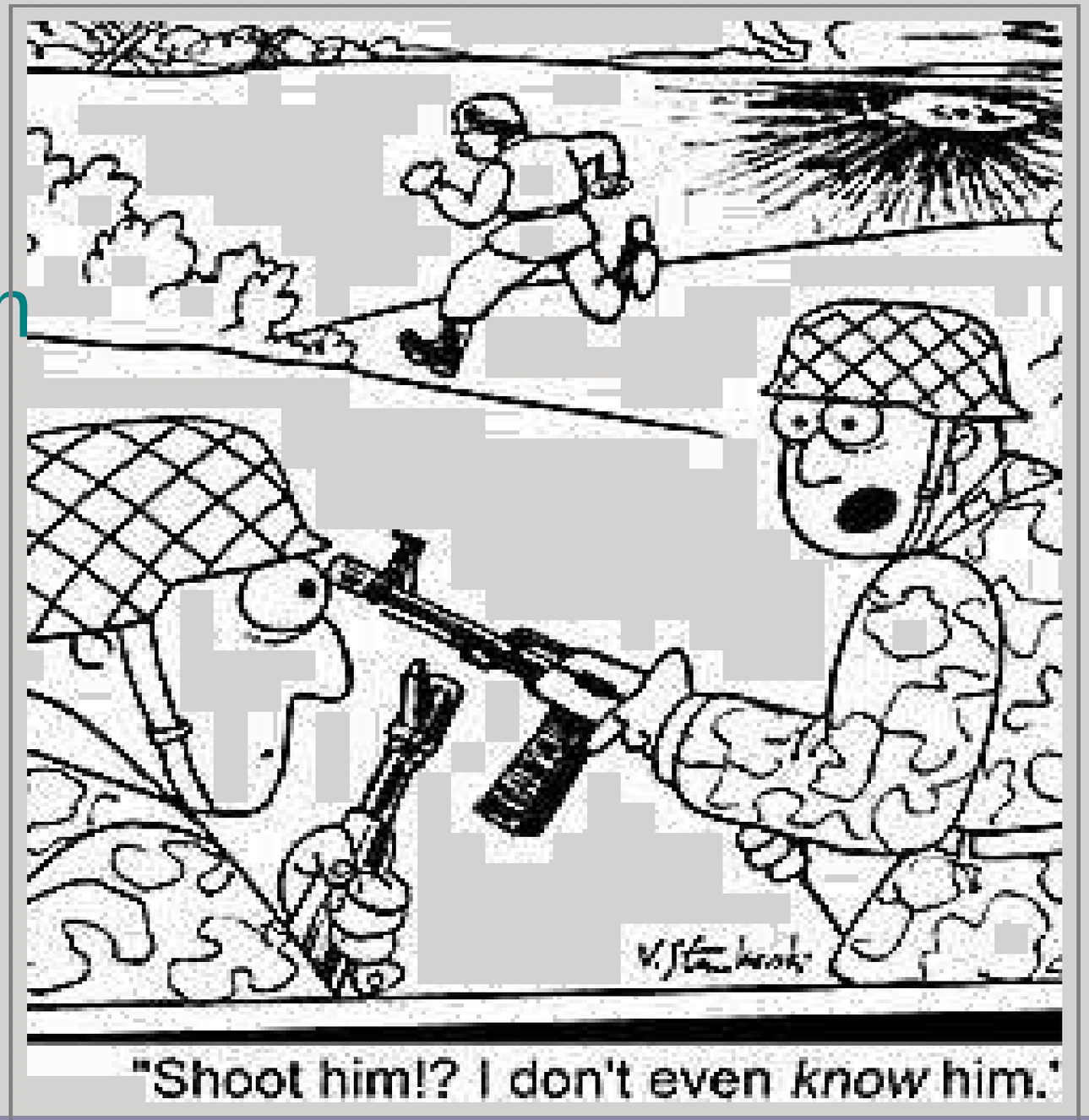


ABFT can be taught to Norwegian Therapists

Challeges of supervision

- Clinical model (flat strukture)

- Research model (fidelity)



Videre lesning om ABFT

fokus 37 36–52

Tilknytningsbasert familieterapi for deprimert ungdom

PRAVIN ISRAEL OG GUY S. DIAMOND

Det er en økende interesse for behandlingsmetoder som støttes av empirisk forskning for deprimert ungdom. Imidlertid, mens studier av psykososial og farmakologisk behandling ser lovende ut, er det bekymring omkring deres effektivitet og mulig bivirkning som økte selvmords tanker. En ny og innovativ familiebehandling for deprimert ungdom med empirisk støtte, er tilknytningsbasert familieterapi (ABFT). Den teoretiske ramme for modellen er ungdomstilknytningsteori. Basert på teorien, fokuseres det i den første halvdelen av behandlingen på å hjelpe ungdommen å identifisere og snakke om tidligere og nåværende familie konflikter som har medført en brist i tilknytningsrelasjonen og ødelagt tillit. Den andre halvdelen av behandlingen fokuserer på promotering av ungdommens autonomi, for eksempel, bedre skole produktivitet, finne seg en jobb, utvikle eller vende tilbake til sosiale aktiviteter. Fem behandlingsoppgaver sørge for å oppnå målet ovennfor. Hver oppgave kan oppnås i en eller flere behandlingstimer. ABFT har samlet seg empirisk støtte for å redusere depresjon og selvmords tanker hos ungdom med klinisk depresjon. For øyeblikket foregår det en randomisert klinisk studie ved barne-og ungdomspsykiatrisk avdeling, Stavanger, Norge, for å vurdere effektivitet av ABFT med deprimerte norske ungdom.

Pravin Israel, dr.psychol., er spesialist i klinisk psykologi og NFR post-doc.-stipendiat ved Barne- og ungdomspsykiatrisk avdeling, Stavanger Universitetssykehus. Henvendelser kan rettes til Barne- og ungdomspsykiatrisk avdeling, Stavanger Universitetssykehus, Postboks 8100 Hillevåg, 4068 Stavanger. E-post: pravin@sus.no
Guy S. Diamond, Ph.D., er direktør ved Center for Family Intervention Science, Children's Hospital of Philadelphia og Associate Professor ved University of Pennsylvania, School of Medicine

Det er en økende interesse for behandlingsmetoder som støttes av empirisk forskning på deprimert ungdom. Flere studier viser at kognitiv atferdsterapi (CBT) har god behandlingseffekt, reduserer depresjon hos barn og ungdom (Butler, Mietzitis, Friedman

depressive symptomer (Jaycox, Reivich, Gillham & Seligman 1994). Mufson, Dorta, Moreau & Weissman (2005) rapporterte lovende funn for interpersonlig psykoterapi (IPT) som en behandlingstilnærming for depresjon hos ungdom. Medisinering med anti-

høyere enn 50 prosent (Barrington, Prior, Richardson & Allen 2005). TADS (Treatment of Adolescents with Depression Study) var den første studien som viste at medisinering ga bedre behandlingseffekt enn CBT. Imidlertid var en kombinasjon av de to det beste. Bekymring omkring suicidale tanker som en uheldig bivirkning ved medisinering gjør imidlertid dessverre dette behandlingsalternativet mindre attraktivt. Videre reiser dårlige behandlingsresultater ved CBT alene nye spørsmål ved metodens effektivitet og anvendbarhet. Til sammen viser dette et fortsatt sterkt behov for nye og effektive behandlingsmetoder for depresjon hos ungdom.

I forrige tiår fikk familietilnærminger ved behandling av depresjon økende popularitet (Diamond & Josephson 2005). Forskning forteller en konsistent historie: at familiefaktorer spiller en viktig rolle for utvikling, opprettholdelse og tilbakefall av depresjon. For eksempel har høy grad av kritikk, kontroll, en autoritær foreldrestil og dårlig tilknytning alle vist seg å ha sammenheng med depresjon hos ungdom (Asarnow, Goldstein, Tompson & Guthrie 1993; Brent et al. 1997; Sheeber, Hops & Davis 2001). Familien har dessuten en viktig beskyttende funksjon når det kommer til forebygging og forhindring av tilbakefall av depresjon.

Gitt den betydning familierelasjoner har for depresjon hos ungdom, har enkelte teraforskere begynt å inkludere foreldre i behandlingen. Lewinsohn et al. (1990) og Stark, Swearer, Kurowski & Sommer (1996) inkluderte foreldre i en CBT-basert behand-

dre kliniske tjenester (f.eks. medikamentell behandling, individualterapi osv.). En ny og innovativ familiebehandling for deprimert ungdom som samler empirisk støtte, er tilknytningsbasert familieterapi (Attachment Based Family Therapy – ABFT; Diamond, Reis, Diamond, Siqueland & Isaacs 2002). ABFT er en empirisk basert metode som har sine røtter i utviklingspsykologi og familiepsykologi. Denne artikkelen gir en kort innføring i ABFT-metoden.

Prinsipper og mål i ABFT

Deprimert ungdom ofte kommer til terapi med en følelse av håpløshet, ensomhet og sinne rettet mot sine foreldre som ikke forstår, eller misforstår deres fortvilelse. Foreldrene har egne erfaringer med tilknytning og intimitet som gjør dem ambivalente, og de føler frustrasjon over de mislykkede forsøk på å hjelpe barnet sitt. Disse såre erfaringene forårsaket av mangler i tilknytningen og som strekker seg over generasjoner, framstår ofte som fordekte atferdsproblemer hos den unge. Dette medfører høy grad av konflikt mellom ungdommen og foreldrene. Å krangle om lekser og oppgaver som trengs å gjøres i hjemmet, er tryggere enn å ta opp temaer som mishandling, avvisning og vanskjøtsel. Ved å identifisere og diskutere vanskelige temaer som foreldre–barn-relasjoner og medfølgende smertefulle følelser, bygges det en opplevelse av delt sårbarhet og ærlighet. Dette kan styrke og gjenoppbygge ungdommens ønske om tilnytning til foreldrene og gir an-

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

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