Attachment-Based Family Therapy for Depressed and Suicidal Adolescents: Development, Research and Clinical Practice

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Abstract

Attachment-Based Family Therapy (ABFT) is an evidence-based model designed to treat depressed and suicidal adolescents. ABFT works with adolescent psychopathology in the context of family relationships by addressing ruptures in the parent-child relationship and restoring parents' caregiving capacities and adolescents trust in attachment security. This paper provides a rational for family based treatments for this disorder, an overview of clinical model and a review of some of the empirically work supporting the treatment efficacy and effectiveness.

Key words: family therapy, adolescents, depression, suicide, attachment theory

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Every forty seconds, an individual takes his or her own life (Word Health Organisation (WHO), 2015). Unfortunately, a large percentage of these are adolescents. Suicide is the second leading cause of death among youth aged 10-24 (Centre for disease control (CDC), 2013). Approximately 20% of adolescents seriously consider killing themselves at some point during the ages of 12-18. Over one million of these youths attempt suicide each year and between 1,600 and 2,000 die by suicide (American Academy of Child &Adolescent Psychiatry (AACAP), 2001; Grunbaum et al., 2002; Hamilton & Hamilton, 2005). In addition suicide bears vast socio-economic societal costs as a result of medical expenses, missed work and school/college drop-out (CDC, 2013). Given the high burden of suicide on sociological, economic and community accounts, identification of effective prevention and treatment strategies for this population is warranted (CDC, 2013; Nock et al, 2008)

Unfortunately, scientists have given limited attention to developing effective treatments for youth and their families (Olfson , Blanco, Liu, Moreno, & Laje, 2006; Stanley et al, 2009). Some clinical trials have been carried out but results have been inconclusive and show small effect sizes (Asarnow et al., 2011; Brent, Baugher,Chen,Chiappetta,2009;Van Heeringen & Marusic, 2003). Research has been conducted using various clinical approaches including dialectical behavior therapy, CBT, and multi systemic therapy (Brent et al, 2009; Ougrin, Tranah, Leigh,Taylor & Asarnow, 2012 ; Rowe et al, 2014). Unfortunately, they conclude that few treatments have enough positive data to meet the standard of being an empirically supported treatment. Furthermore, promising findings in some research studies have not been successfully

replicated when carried out by independent researchers (Hazell, 2009). There also exists widespread debate over whether medication should be used to treat suicidal ideation as it could potentially increase risk for suicidal behavior (Hammad, Laughren, & Racoosin, 2006). Given these findings, there remains a need for studies that supplement or augment these treatments in order to increase their potency.

One area that has been over looked is a focus on interventions that target or include families as one of the treatment targets. The quality of the adolescent-parent relationship might serve as both a risk and protective factor for adolescent suicidality. In regard to risk factors, extensive research indicates that adolescent suicidal ideation and attempts are more frequent in families characterized as low in cohesion and parental responsiveness and high in conflict (Brent et al., 2009). Prospective and cross-sectional studies in community and clinical samples have linked parental criticism, emotional unresponsiveness, lack of care and support, rejection and parental control to adolescent suicidal ideation and attempts (Brent et al., 2009; Kolves, 2010). Furthermore, at the crucial juncture of adolescent identity development, poor problem solving between adolescents and parents have been shown to exacerbate suicidal ideation and behavior (Rudloph et al., 2000). In contrast, family protective factors include parental emotional attunement, support and trust. These positive family factors have been associated with reduced risk for suicide (Sheeber, Davis, Leve, Hyman, &Tidesly, 2007).

Increasingly, interventions with adolescents have included families in treatment. Most involve family psycho-education or family information sessions combined with CBT and medication (Rotherram-Borus, Piacentinit, Miller, Graae, & Castro-Blanco., 1994; Asarnowet al., 2011). Few studies have actively involved families in therapy and focused on family dynamics themselves (Diamond, 2005). Building family resources and skills as well as

understanding relational dynamics in therapy have found significant improvements as evidenced by reduced suicidal behavior and with gains in social adjustment (Allen, 2009). Family focused interventions also promote the socio-ecological model of behavior and motivate adolescents to cope in healthier ways.

Two relational theories, Joiner's interpersonal theory and Attachment theory, help frame how parent-adolescent relationships, might be beneficial for treatment with suicidal adolescents. Joiner, Van Orden, Witte and Rudd (2009) Interpersonal theory of suicide demonstrates that thwarted belongingness and perceived burdensomeness are strong contributors to suicidal behavior (Orden, Lynam, Hollar, & Joiner, 2006). Thwarted belongingness is the sense that one is separate or distant from friends, family and social connections. Burdensomeness pertains to an individual's feeling they are an inconvenience to family and friends who would be better off without him/her. The helplessness/hopelessness felt by these adolescents, cascades into other systems such as school, peers, and extended family (Beautrais, 2004).

Attachment theory also sheds light on why families might be an important target in youth suicide treatment. The importance of appropriate attachment during adolescence has been well documented (Allen, 2009; Zimmerman & Becker-Stoll, 2002). The core premise in this framework is that secure attachment relationships are marked by confidence in the caregiver's availability to provide support and protection(Bowlby, 1988; Kobak, Cassidy, Lyons-Ruth, & Ziv, 2006; Sroufe, 2005). Secure attachment enables more direct communication between adolescent and parent which foster perspective taking, emotional regulation, and development of problem solving skills or competencies which protect against suicidal ideation and depression (Kobak et al, 2006). The presence of secure attachment solidifies the foundation for an internal capacity to cooperatively resolve conflicts with caregivers, other adults (e.g., teachers), peers,

and romantic partners. In contrast, a caretaker's unavailability and unresponsiveness leads to negative expectancies for caregiver availability and problem solving strategies characterized by disengagement, emotional deregulation, conflict avoidance, aggression and withdrawal (Kobak, et al, 2006). Insecure attachment has repeatedly been associated with depression and suicidality in adolescents and adults (Kobak et al, 2006).

Given the importance of family relationships in promoting health adolescent development, more treatments should consider incorporating interventions that target this domain.

Attachment-Based Family Therapy

Attachment Based Family Therapy (ABFT) is an empirically supported psychotherapy model designed to improve family relationships in order to help adolescent's better cope with depression, suicidal ideation, and trauma. ABFT is an attachment-informed, developmental therapy that fits within the modern tradition of empirically informed family therapy practices along with Multi-systemic Therapy (MST) (Henggeler,Schoenwald, Borduin, Rowland, & Cunningham, 1998) and Multi-Dimensional Family Therapy (MDFT) (Diamond & Liddle, 1999). ABFT is an integrative model and incorporates components of several family and individual therapy approaches.

Although influenced by other theoretical approaches and family therapy traditions (Boszormenyi-Nagy & Spark, 1973; Johnson, 2004; Johnson & Greenberg, 1985; Minuchin, 1974). ABFT has its basis in attachment theory. It operates under the assumption that a child's sense of security and development depends on parental availability and protection (Bowlby, 1988; Rees, 2005; Atilli, Virmigli & Roazzi, 2011). Although it is important in infancy, attachment is relevant throughout one's lifetime and can determine the quality of others life

relationships (Zayas, Mischel, Shoda, & Aber, 2011). In adolescents, healthy attachment promotes autonomy, self-esteem, emotional regulation, and positive peer relations. In adults, however, attachment style has been linked to intimacy in relationships and styles of parenting (Fonagy, 1997; Fonagy, Gergely,Jurist & Target,2002). The ability to communicate vulnerable emotions without fear of rejection, criticism or threat of abandonment is the basis of healthy attachment (Bowlby, 1988; Johnson, 2004).

Ruptured attachment with parents and a negative family environment, inhibit children from developing the internal and interpersonal coping skills. These skills are needed to buffer against biological vulnerabilities and social stressors that can cause or exacerbate depression and struggles with suicidal ideation (Rudloph et al, 2000). Clinically, families often express underlying attachment ruptures through every day, conflictual interaction about chores, curfews, and school. These stressful interactions with parents are associated with the adolescents' depression, engagement in risky behavior, substance use, and unsafe sexual practices (Nock et al, 2008).

The underlying assumption of ABFT is that insecure attachment bonds, characterized by high conflict, harsh criticism, and/or low affective attunement, can lead to feelings of emotional neglect, abandonment, rejection and disappointment (Bowlby, 1988). Furthermore parental psychopathology or parents' own insecure attachments can spill over into ineffective modes of parenting (Kaslow & Racusin, 1994; Sheeber et al, 2007). An equally important aspect is that attachment ruptures can be repaired (e.g., parents can become better caregivers and trust can be built or rebuilt).

The goal of ABFT is to promote security in the relationship between parent and child, target current or prior ruptures in attachment security, and develop models of successful

emotional attunement (Diamond, 2005; Diamond et al, 2010). Therapists accomplish this by systematically identifying and repairing attachment ruptures, core family conflicts (e.g., physical or emotional abuse, neglect, and/or abandonment), and associated vulnerable emotions such as sadness, fear, and disappointment. Discussing these vulnerable feelings against the frame of attachment needs can create resolution, or even just recognition, of these family traumas that can help re-establish the family as a secure base. Once this secure haven is created, it can serve as a safety net that buffers against feelings of depression and suicidal ideation. Parents can once again provide support and guidance to their adolescent as he or she strives for autonomy and competency. Adolescents can then continue on a normative developmental trajectory (Diamond, Diamond & Levy, 2014).

The Clinical Model

The treatment manual is organized around five treatment tasks (Diamond et al,2014). The clinical model of these tasks is detailed in Table 1

<INSERT TABLE 1 HERE>

Treatment Tasks

Repairing attachment and promoting autonomy are the overarching goals of ABFT. These goals are achieved through five specific treatment tasks. These tasks are described in detail below.

The *Relational Reframe Task* sets the foundation for treatment by shifting the family's focus from "fixing" the adolescent to improving family relationships (Siqueland, Rynn, & Diamond, 2005). The Relational Reframe is completed in one session, typically the first therapy session. After a comprehensive history has been taken, the therapist intentionally shifts the focus

on to the family relationships and addresses what gets in the way of the parents being a resource for the adolescent who needs support when feeling suicidal. Working on family relationships is introduced as the first goal of therapy and family members contract to work on their relationship with the therapist.

The *Adolescent Alliance-Building Task* is conducted individually with the adolescent and typically lasts between two and four sessions. It focuses on building a therapist–adolescent bond as the therapist begins acquiring information on the context of the adolescents' life, their values and important aspects of identity. The history of the depression is obtained and the therapist helps the adolescent articulate their suicide narrative. The therapist then shifts to understanding parent-adolescent ruptures that have inhibited trust in the relationship and have caused distress. He/she then proceeds to help adolescents identify causes of their pain and the consequences of relational ruptures. The therapist punctuates the need to discuss these ruptures with their parents. With the adolescent's agreement, the therapist prepares him or her to discuss these issues with the parent's . During the *Alliance-Building Task*, the therapist serves as a secure base for the adolescent as they learn to express their personal narrative in a regulated way.

The *Parent Alliance-Building Task* occurs simultaneously with the *Adolescent Alliance Building Task* and also lasts between two and four sessions. It involves meeting with the parent's alone and begins with an exploration of the parents' current stressors. The therapist helps the parent's gain insight on how their stressors may be affecting their parenting and their child's experience. In order to help the parent's gain empathy for the child's experience and motivate primal caregiving instincts, the therapist explores the parents' own history of attachment disappointments (Feder & Diamond, 2016). The therapist helps the parent's understand how these experiences in form the parents' view of their adolescent and their parenting style.

Consequently, parents become more receptive and promote communication. The therapist can then equip the parent's by emotionally coaching them to convey this empathetic and sensitive caregiving to their adolescent when reunited in sessions.

The *Attachment Task* serves as a corrective attachment experience between parent's and child. This task typically lasts between one and four sessions depending on the complexity and the amount of ruptures being discussed. The task begins with the adolescent disclosing previously unaddressed hurt, anger, or pain to their parent's. These ruptures may include feelings or experiences involving betrayal, abuse, abandonment, neglect, or rejection. Once the parents respond empathetically and offer support, the adolescent is encouraged to deepen these painful experiences by rooting them in sadness and disappointment that contributed to their suicidality. The therapist aids the parent's to be empathetic and supportive in this process. Parents often offer sincere remorse for letting their adolescent feel such pain, which helps the family reach common ground and start the process of repairing the attachment bond. Although many of these ruptures are complex and may not achieve immediate resolution, open discussion serves to create trust, diffuse tension and improve affect regulation. The adolescent can now start to see the parent's as a resource and can digest more parental authority, even becoming more sensitive to parental needs (Siqueland et al, 2005).

The final task, *Promoting Competence*, fosters the adolescent's healthy expression of self and aids in the development of autonomy. This task allows the family to address a broader range of topics on the adolescent's emerging identity now that a secure base has been established or restored. *Promoting Competence* tasks typically involve five or more sessions where parent and adolescent are encouraged to discuss topics such as social support systems, school problems, hobbies, self-esteem, relationships, sexuality, and sibling concerns. Families can also talk about

identity issues such as religious beliefs and affiliations, ethnicity, gender and sexual identity. It is also a chance parents to negotiate the adolescent's responsibilities within the home, such as rules and chores.

Overview of Research

ABFT has been supported by a decade of empirical research. In this section, we will review outcome and effectiveness research. Table 2 provides an overview of each of these studies. The first pilot study for ABFT was conducted in 2002 and was funded by the American Foundation for Suicide Prevention (AFSP) and the National Alliance for Research in Schizophrenia and Depression (NARSAD) (Diamond, Reis, Diamond, Siqueland & Issacs, 2002). The investigators examined the efficacy of ABFT in the treatment of adolescent depression, measured by the Beck Depression Inventory (BDI-II) Beck, Steer & Garben 1988). Family functioning was also measured via the Self-Report of Family Functioning (Beavers & Hampson, 2000). Adolescents were interviewed on the depression section of the Schedule for Affective Disorders and Schizophrenia (K-SADS-P) and on the Brief Symptom Inventory (BSI). Parent measures included a Child Behavior Checklist. The sample consisted of 32 adolescents, the majority of whom were African American girls, who were randomized to either ABFT or no treatment. Treatment lasted 12 weeks and participants were assessed at baseline, mid-point (6 weeks) and end of treatment (12 weeks). They were followed up to 6 months. Participants attended an average of eight, 60 to 90 minute sessions across the 12 weeks. The waitlist control group received 15 minute monitoring phone calls to assess any deterioration as measured by the BDI.

<INSERT TABLE 2 HERE>

At post treatment, 81% of participants randomized to ABFT no longer met criteria for Major Depressive Disorder (MDD) compared to only 47% in the waitlist group who were then offered ABFT treatment (Diamond, Siqueland & Diamond,2003). Mixed factorial analyses of variance revealed reduced symptoms of anxiety, depression and family conflict in the ABFT group. A 6 month follow up with 15 of the original 16 clients randomized to ABFT found that 13 of the 15 assessed (87%) no longer met criteria for MDD. Other ABFT studies have similarly had over 80% follow-up with reduced reported symptomatology at 6 month follow up (Diamond et al., 2010; 2012). Follow up duration and measurement is described in detail (See Table 4). In this study, the developers included a culturally diverse group of male and female therapists who identified as African American, Latina, and White, both male and female. All therapists received training and weekly supervision, including regular live supervision (Diamond et al, 2002).

<INSERT TABLE 4 HERE>

The next major randomized control trial examined the effects of suicidal ideation and depressive symptoms using ABFT treatment versus treatment as usual with 66 adolescents (Diamond et al., 2010). This study found reduced suicidality and depression, improved family functioning and reduced conflict within the participants receiving ABFT (M = 5.2, 95% confidence interval [CI], 1.6-8.8) as against treatment as usual (M = 16.2, 95% CI, 10.1-22.2) (Diamond et al, 2010).

A current large scale randomized control trial, which is yet to be published, consists of a five year study of 129 families with a suicidal adolescent. Funded by the National Institute of Mental Health (NIMH), This study tracks families after 16 weeks of treatment, at several regular

intervals with outcome measurements at baseline, 4 weeks, 8 weeks, 12 weeks, 16 weeks, 32 and 54 weeks post treatment (Diamond et al., 2010).Within- sample reliability for the populations in these studies found scores at ≥ 0.85 (Diamond et al., 2010).

The outcome and process measures have been described across studies in detail (See Table 3). The outcome measures have rigorously integrated both parents and adolescents in assessments. Family interactions have also been assessed and coded via a parent-adolescent interaction task where conflict between parents and adolescent is monitored and patterns of communication and/or emotional expression observed (Diamond et al, 2010). This assessment is done at baseline as well as post treatment and scored for changes in interactions. In terms of newer, more innovative assessments, there is also ongoing research being conducted on active client emotional processing in response to therapist interventions in specific sessions for suicidal adolescents and young adults (Shelef, Diamond & Liddle, 2005). All therapy and assessment sessions are videotaped with the consent of participants and give deep insight into moment by moment elements(Diamond et al., 2003). Attachment style is also evaluated through the Adult Attachment Interview (AAI). This tool addresses intrapsychic processes over and above self-report assessments. The client satisfaction questionnaires (CSQ), adolescent service utilization, and Cornell Services Index (CSI) lend insight on feasibility and acceptance of the study from the participant's perspective.

<INSERT TABLE 3 HERE>

Treatment Fidelity

Adherence in psychotherapy for families is relevant since the parent–therapist alliance has been shown to be associated with treatment retention and the quality of the adolescent therapist alliance predicts outcome (Shelef et al.,2005). The developers of ABFT have been concerned about evaluating fidelity in two important ways (Diamond, Diamond & Hogue, 2007). Treatment fidelity comprises two related but distinct issues: adherence and differentiation. Adherence refers to whether a treatment was delivered in accordance with the essential theoretical and procedural aspects of the intervention model. Treatment differentiation, on the other hand, refers to the degree to which a treatment differs from other treatments. In the context of comparative clinical trials, adherence data provides a measure of internal validity of the treatment while differentiation data provide a measure of discriminant validity required to draw conclusions regarding the link between specific intervention models and outcome (Hogue & Dauber, 2013).

For adherence measurement in ABFT, trained observers used the Therapist Behavior Rating Scale (TBRS, 2007) to code therapists' behaviors in 45 sessions of ABFT and 45 sessions across two other empirically based treatments, Multi-dimensional Family Therapy (MDFT) and Cognitive Behavior Therapy (CBT). The TBRS attempted to capture ABFT therapist behaviors across five tasks, general family therapy skills and alliance building skills.

Several items captured the essential interventions of ABFT such as the relational reframe, vulnerable emotions, addressing attachment ruptures and so on. The measure included cognitive-behavioral interventions (e.g., cognitive monitoring, behavioral interventions, etc.), family therapy interventions (e.g., parental monitoring, coaching, in-session enactments, etc.), and common facilitative interventions (e.g., expressing interest, forming treatment goals, generating hope, etc.). Out of these 20 items, 16 items were unique to ABFT and an interclass correlation

was conducted leading to coefficients 0.72 to 0.96. Factor analysis revealed that ABFT could be characterized to have a unique intervention focus.

To validate the instrument, 10 external raters were trained for 40 hours, mostly undergraduate students. 50 videotapes of ABFT were rated twice. Inter-rater reliability was found to be 0.9 or higher (Diamond et al., 2002; Diamond et al, 2007). The TBRS showed high reliability between ABFT items as against MDFT and CBT (Diamond et al, 1996). Currently underway is an adherence study with a combined tools developed to evaluate the fidelity for each task of the ABFT treatment model and aspects of the control treatment NST. It checks whether the therapists applied specific ABFT interventions and whether the use of such interventions varied, as expected, according to treatment stage (i.e., early vs. late). Further more, it checks if non-specific elements of NST were also utilized in ABFT tapes. Inter-rater reliability is being established with a team of four trained and objective coders where every 5th tape is double coded for accuracy. In all prior studies, inter rater reliability on the adherence scale has been 0.86, 0.9 and 0.95 (Diamond, Levy, & Creed, 2011; Diamond et al., 2012).

ABFT with Diverse Populations

ABFT has been tested with several populations of adolescents and the efficacy is now being assessed with young adults, especially with youth from the LGB community (Diamond, Shahar, Sabo & Tsvieli, 2015). Studies have included families from inter-city and urban environments as well as adolescents with diverse racial and sexual identities (Diamond et al., 2012; Diamond et al., 2002). Although the majority of adolescents participating in ABFT research have historically been African American girls, more recent research has included Latino, White, and Asian American boys and girls. In addition, most families involved in ABFT

research have been socio-economically diverse, coming from backgrounds of economic hardship and deprivation, a lack of social support and resources (e.g., secure housing) and limited access to quality education or healthcare.

ABFT has also been tested to treat disorders other than depression and suicidality. For example, ABFT was used for a sample of teens diagnosed with anxiety disorders (Siquelan et al,, 2005). In this study, anxious adolescents were treated with a combination of CBT and ABFT. Outcomes showed that this treatment was successful in addressing adolescent anxiety as assessed by a clinically evaluated decrease in symptoms and via self-report. In the CBT-ABFT group, 40% of participants no longer met symptoms of depression or anxiety, with 80% continuing improvement at follow up. Further research in this area is warranted (Siqueland et al., 2005)

LGBQ Adolescents. Research indicates that LGBTQ youth are at a much higher risk for suicide then heterosexual youth (Duncan & Hatzenbuehler, 2014; King et al., 2008; Mustanski & Liu, 2013). The ABFT developers have taken a special interest in treatment development for this population. A recent study adapted the ABFT model to treat suicidal and depressed LGB adolescents and piloted the new manual on 10 cases (Diamond et al, 2012).The manual was specifically adapted to suit the needs of this population and included session content on gender expression. This adaptation of ABFT also included more time with parents in order to 1) Process their emotions about their adolescent's sexual identity; 2) Understand acceptance processes; and 3) Increase awareness of subtle, yet potent, invalidating responses to their adolescents' identity (Diamond et al., 2012).

Aftercare. A small ABFT study was also conducted with 32 adolescents and their families for adolescents post suicide attempt from an in-patient treatment center at the Children's Hospital of Philadelphia to assess the contribution of ABFT in the maintenance of safety

prevention of future attempts (Diamond et al, 2011). It was observed that hospitalization often plays the role of stabilization rather than remission care. In this study, ABFT was compared with Enhanced Usual Care (EUC). It was found that ABFT influenced moderating factors of depression and suicide like impulse control, family conflict, and negative interactions with parents. Suicidal ideations did not reduce significantly, but less self-reported psychopathology and healthier coping was noted (Diamond et al., 2011). Although this study was promising for the scope of ABFT with primary care and emergency facilities, further research in necessary to assess feasibility and ensure retention.

Suicide and History of Sexual Abuse. Several studies suggest that a history of sexual abuse (HSA) is an important moderator of treatment outcome among adolescents with suicide ideation (Eisenberg, Ackard & Resinick, 2007; Klonsky, 2008; Joiner et al, 2007). Adolescents with a HSA are likely to have higher levels of suicide ideation and attempts than those without suicide ideation (Bergen et al, 2010; Eskin, Kaynak-Demir, & Demir, 2005). Studies show a strong association between a history of sexual trauma in childhood and the presence of suicide ideation in adolescence or adulthood (Sareen et al., 2007). Individuals with a history of childhood trauma are also two to five times more likely to attempt suicide in their lifetime. In light of this, many studies have suggested the need for intervention approaches that target these populations (Tarrier, Taylor, & Gooding, 2008; Hammad, et al., 2006).

There have been some empirical studies with suicidal adolescents who had a history of sexual abuse. Using data from a study by Brent et al. (1999), researchers found that cognitive-behavioral therapy (CBT) was more efficacious than non-directive supportive therapy in suicidal individuals (Barbe et al, 2004). When looking at a sub-population of this sample with a history of abuse, they found that these differences were no longer significant when moderated by a HSA

(Barbe, Bridge, Birmaher, Kolko & B, 2004). In another study, Asarnow et al. (2011) founded that in the Treatment of Selective Serotonin Reuptake Inhibitor (SSRI) Resistant Depression in Adolescents study (TORDIA), a history of sexual abuse was an important moderator in treatment, along with a few other variables.

In the absence of proven treatments for populations with a history of sexual abuse, it might be imperative to look beyond individual psychiatric factors such as adolescents' cognitions and ineffective forms of coping. A non-psychiatric factor like HSA can often go unnoticed by family therapists where families present with poor communication, high family conflict, and low cohesion. Interventions that target the family's role in processing past trauma and its influence in current manifestations of suicidal behavior might improve the efficacy of treatment with this population (Diamond et al, 2012).

Dissemination of ABFT

Although there have been several efficacy studies in ABFT, effectiveness and dissemination studies are limited. An ABFT dissemination study with 20 depressed adolescents aged 13-17, was conducted in Norway by an investigator who was not the treatment developer (Israel & Diamond, 2013). Interestingly, implementation barriers rapidly emerged in relation to hospital administration, infrastructure development, and therapists. The clinic-referred adolescents were randomly assigned to ABFT (n= 11) or to Treatment as Usual (TAU) (n= 9). The Beck Depression Inventory (BDI) was used bi-weekly to monitor depressive symptoms and the Hamilton Scale (HAM-D) was administered at 12 week post-treatment assessment. The project was approved by the Regional Ethics Committee (REK-III) in Norway. Feasibility was evaluated by ongoing observation and documentation of the implementation process. Acceptability was evaluated by retention of adolescents in treatment.

Adolescents in ABFT showed significantly better symptom reduction compared to adolescents in TAU with an effect size of 1.08. They also attended more therapy sessions depicting that the treatment had reasonable acceptability. While preliminary, this study suggests that Norwegian clinical staff therapists could be engaged in learning and delivering ABFT, and produce promising treatment results.

Conclusion

This paper reviews the scientific development of ABFT as an evidence based model. Research studies indicate that ABFT is an emerging model with empirical and clinical value. Across clinical trials, the sample sizes have gotten bigger and more diverse, control groups have become more rigorous, measurements have expanded and different domains of therapy have been addressed (Diamond et al, 2010). Many new areas of research have been initiated: ABFT with eating disorders, college students, and importing the model to Mexico. Training a new research team in another culture is no doubt challenging as found in the Norwegian clinic study (Israel et al, 2013). Even so, ABFT is currently being implemented in over 7 countries including Australia, Belgium, Norway and the UK. We have trained over 3000 provides to use the model and many are now certified. Over all, ABFT is gaining attention and interest and should experience continued growth and development over the next decade.

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Table 1:Targets and Proposed Mechanisms of Change

Problem state	**Treatment Tasks**	**Expected Outcomes**
Parent criticism/ Hostility	Relational Reframe	Reduce blame/ Increase mutual respect
Low adolescent motivation	Alliance Building	Bonding, identifying engagement goals, commitment to treatment.
Parental Stress, Ineffective Parenting	Parent Alliance Building	Promote emotional, authoritative parenting, emotional coaching
Family Disengagement	Reattachment Task	Rebuilding trust & Dependability
Negative Self-concept	Promoting Competency Task	Increasing Autonomy

Source: Dimaond, Diamond & Levy, 2014.

Table 2*:* Details of research studies in ABFT

Study reviewed and year	Type	Major Outcome measures	Reliability of measures (in-sample)	Manual Adaptations/norms	Demographics
Diamond et al., 2002	Open Trial	Beck Depression Inventory (BDI), Self report of Family Functioning (SSRF),	α = 0.88, 0.89, 0.95 respectively	Not done	78% female & 69% low income, inter-city African-American community
Diamond et al.,2010	Randomized Control Trial (RCT)	BDI, Scale for Suicidal Ideation (SSI),Suicidal Ideation Questionnaire (SIQ)	α = 0.91,0.93,0.95 respectively	Not done	66% female, 74% low income, 58% African American, 28% Hispanic
Diamond et al.,2007	Fidelity process research	Therapist Behaviour Rating Scale (TBRS)	α = 0.92	n/a	Tapes of sessions from above studies
Diamond et al.,2010	ABFT LGBQ population	SIQ, BDI, Relationship Structures Questionnaire (RSQ)	α = 0.94, 0.91 &0.88 respectively	Adapted for sample	34% black, largely women
Diamond et al.,2011	Aftercare study with suicide attempters	BDI, RSQ, SIQ, Columbia Scale for Suicide Severity(CSSR),SIS, Relatedness Scale(RS)	α= 0.95, 0.92, 0.94, 0.85 & 0.89 respectively	Not done	52% African American, 42% white, 6% other
Israel et al., 2013	Dissemination study in Israel Clinic	BDI, Hamilton Depression Inventory(HDI),Youth Self Report (YSR), Kiddie Schedule for Affective Disorder & Schizophrenia(K-SADS)	Not reported	Adapted for the sample	Norwegian patients, middle class, 55% girls
		Source:			

Table 3*:* Studies and Measures Used

Study	Measures Used
Pilot (Diamond et al., 2002)	Beck Depression Inventory(BDI-II), Hamilton Depression Inventory (HAM-D), Self-Report of Family Functioning (SRFF), Suicidal Ideation Questionnaire (SIQ), Kiddie-Schedule for Affective Disorders and Schizophrenia (KSADS-P) , Parent Peer Attachment Inventory
Randomized Control Trial with Treatment as Usual (Diamond et al.,2010)	SIQ, BDI-II, Diagnostic Inventory Scale Children (DISC)
LGBQ study (Diamond et al.,2010)	RSQ-Anxiety&Avoidance, SIQ, BDI Reliable Change Index (RCI)
Norway Dissemination Study (Israel et al.,2013)	HAM-D, BDI, Youth Self Report(YSR), K-SADS, Reliability Change Index (RCI), Client Satisfaction Questionnaire (CSQ), Cornell Services Index (CSI)
Aftercare Study (Diamond et al., 2011)	BDI, Relatedness Scale (RS), RSQ, SIQ, Suicide Intent Scale (SIS), Columbia Suicide Severity Scale (C-SSRS), CSQ, CSI

Source:

Table 4: *Follow up and outcomes*

Study	Follow up time points	Follow up outcomes
Diamond et al., 2002	Mid treatment(6weeks), end treatment(12weeks) & follow up (6 months)	81% no longer classified for MDD compared to 47% on waitlist control
Diamond et al., 2010	4 weeks, 6 weeks, 8 weeks, 12 weeks, 16 weeks (end treatment), follow up (6 months)	Reduced levels of suicidality and depression being no longer clinically diagnosable, improved family functioning and reduced conflict
Diamond et al., 2011	Baseline and post treatment (12 weeks)	No significant reduction in suicidal ideation, reduced rates of depression and improved relatedness
Diamond et al., 2012	Baseline, 6 weeks and 12 weeks(post treatment)	Decrease in suicidal ideation, depression and attachment anxiety as well as avoidance
Diamond et al., 2013	Follow up 6 months	Significant symptom reduction and reliable change index scores reported

Source: