

Attachment-based Family Therapy for Reducing Suicidal Ideation and Depression in Adolescents

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Adolescent Suicide

- Every year 1 in 5 adolescents contemplates suicide, 5 to 8% attempt suicide and approximately 1,600 to 2,000 adolescents die by suicide
- When you take into account non-lethal attempts, approximately one million teenagers attempt suicide each year

Suicide Treatment and Prevention Research

- Less than 10 published studies on psychotherapy for suicidal youth.
- In many of the studies, experimental treatment does no better than Treatment As Usual in reducing suicide attempts or ideation.
- In many studies, there was no difference between experimental and control treatment.
- There are no psychopharmacology studies for suicidal youth and much controversy about its impact on suicidal ideation.

Preventing Youth Suicide In Primary Care: A Family Safety Net Approach

- Funded by the Centers for Disease Control and Prevention
- Three year project
- Collaboration between the Center for Family Intervention Science and several primary care clinics

Why Family Intervention? Family as Risk Factor

- Negative family functioning is a strong risk factor for youth suicide and depression: conflict, parental abdication, low cohesion poor attachment
- Adolescent suicide strongly associated with families with a history of suicide, sexual abuse, violence, physical and emotional abandonment, and chronic conflict
- Family conflict often precipitates suicide attempts, preceding 20% of completed suicides and 50% of non-fatal suicidal episodes (Brent et al., 1988)

Why Family Treatment? Family as Protective Factor

- Extensive research suggest that supportive parent-child relationship and parental monitoring are associated with better child functioning, less suicide and lower depression.
- The natural developmental and protective context of child development (American Academy of Pediatrics, 2000)

Family As Safety Net

- In collaboration with teachers, medical staff, probation officers or other social services, parents can decrease the burden to professional by monitoring patient safety

Suicidal Crisis as Therapeutic Opportunity

- Suicide as adolescent's call for help
- Life-threatening problem activates caregiver protective instincts
- Diffusing family conflict allows parents to become natural protective context to support adolescent autonomy development

Over view

- Generally 12 to 16 sessions
- Empirically informed and supported
- Built around 5 distinct yet interrelated treatment “tasks”
- Manual is focused but flexible
- Based in attachment theory and Structural Family Therapy

A Balance of Attachment and Autonomy

- Normative adolescent development occurs in the context of loving, respectful (though sometimes frustrating and tense) parent-adolescent relations.
- Sustained adolescent-parent engagement during the adolescent years is essential.

Family Processes that Rupture Attachment

- High conflict/Low cohesion
- Parental high control, low affection
- Parental criticism
- Parental psychopathology
(e.g., depression, substance use, etc)
- Negative family life events
(e.g., divorce, abandonment, abuse, neglect)

Crisis as Therapeutic Opportunity

- Crisis as adolescent's call for help
- Life threatening problems activate caregiver's protective instincts and adolescents' desire for protection (e.g. suicide, arrest).
- If effectively used, crisis creates an opportunity for a **“corrective attachment experience”**

Corrective Attachment Experiences

- When adolescents are able to express their attachment related feelings and needs (positive or negative) in a direct and regulated manner, and parents respond with care, respect, and authority, families have a moment of experiential learning about family competency.

What is ABFT?

- Series of in-session episodes that prepare for and facilitate corrective attachment experiences.
- As parents demonstrate a caring, non-critical, open, and supportive manner, adolescents begin to perceive and use their parents as caring, safe, protective attachment figures.

Enactment of Effective Attachment: Adolescents

- Identification of core family conflicts and disappointments
- Increase capacity to put feelings into words
- Increase tolerance and ability to manage high emotional arousal
- Increase expectation of fairness in interpersonal relations
- Enhance capacity for insight and perspective taking.

Enactment of Effective Attachment: Parent

- Resuscitate or revitalize parental commitment
- Enhance empathic sensitivity toward own and child's attachment losses
- Adopt a developmentally appropriate view of parenting: balancing attachment and autonomy
- Increase sensitivity to emotional development
- Improve behavioral management skills

Psychological Result of Corrective Attachment Experience

- Reduces adolescent's fear and avoidance of interactions with parents
- Generates intimacy and sense of being cared for thus increasing adolescents' approach behavior
- Repeated positive interactions serve to change adolescents' fundamental attachment schema
- Parent becomes source of validation, support, protection and guidance in adolescent's life (and in times of stress, a buffer against depression and distress)

ABFT: Targeted Problem Areas

- Family criticism (Asarnow, 1993; Sheber et al., 1997)
- Adolescent motivation
- Parental stress/ineffective parenting (Zahn-Waxler, 2002)
- Disengagement/family conflict
 - (Kaslow et al., 1996)
- Poor Affect Regulation (Garber et al., 2002)
- Negative self concept (Beck, 1967; Cole, 1990)

Five Treatment Tasks

- Relational Reframe
- Alliance with the Adolescent
- Alliance with the Parent
- Reattachment Task
- Promoting Competency Task

Task #1: Relational Reframe

- Shifting from patient as problem to family relationships as solution
 - New content: Relational rupture becomes the focus of treatment
 - New Affect: From blame and anger to longing and empathy
 - New expectations: Puts burden of change on all family members

Goals of the Relational Reframe

- Make relationship building the initial goal of treatment
- Reduce blame and criticism, and identify positive (though misguided or covert) motivations for behaviors.

Opening Statements

- When your son feels so suicidal, why doesn't he come and talk to you about it?
- Why has your child become afraid of you?
- What has gotten in the way of you being a resource to your daughter?
- Why have you lost trust in your mother?
- People in this family seem very sad! Why do you think this is so?
- Why have you fired your parents? You won't let her be your mother.

ABFT: Building Alliance With Adolescents

- Bond: Getting to know the teen
- Goals: Identifying core conflicts
- Task: Commitment and preparation for reattachment task

BOND

- Bond Intention:

Engagement
Identify Strengths
From Authority to Ally

GOALS

Intention

- Link depression to family conflicts
- Make resolution of these conflicts a meaningful goal.
- Make this therapy your own

GOALS

Outcome:

Get adolescent on record saying:

- “I’m miserable and I fight with my parents all the time
- I would like things to be different
- What I have tried has failed
- If I could do something to make things better I would

TASK

Tasks Intention

- Get the adolescent to agree to discuss these problems with his or her parents
- Identify and resolve barriers to the success of this conversation
- Prepare for the reattachment task

ABFT: Building Alliance With the Parent

- Bond: Understanding the context of parenting.
- Goals: Teach emotional coaching skills.
- Task: Commitment to and preparation for reattachment task

PHASE I: BOND

1. Build alliance with parent
 - Parent feel appreciated
 - Parent see therapist as a resource
2. Look for obstacles that inhibit relationship building
3. Look for strengths that facilitate relationship building

TRANSITIONAL STATEMENT TO PHASE II:

“How do you think these things have impacted your parenting?”

Intergenerational Strategies

- What was your relationship like with your parents?
- “It was good.” Then it must be disappointing that you do not have that with your daughter.
- “It was Bad.” Then you must know how painful it is to not have your parents available to you.

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

ABFT: Reattachment Task

- Adolescent disclosure of core conflicts
- Parental acknowledgement and respect
- Mutual responsibility and commitment to change

Reattachment Task

- Adolescent disclosure of core conflicts
- Parental acknowledgement and respect
- Mutual responsibility and commitment to change

Task 4

- Phase 1:** Attachment Task Marker
- Phase 2:** Adolescent Anger
- Phase 3:** Adolescent Vulnerable Emotions
- Phase 4:** Adolescent Cognitive Attributions
- Phase 5:** Parent Disclosure and Apology
- Phase 6:** Adol. Ambivalence, Deeper Vuln. Emotions
- Phase 7:** Relational Reframe
- Phase 8:** Deepening of Forgiveness Process
- Phase 9:** Wrap-up

ABFT: Competency Promoting Task

- Self esteem as a buffer against stress.
Identifying appropriate challenges.
Rebuilding the adolescent's social world.
- Parents as a secure base: Support & expectation

Demographic Characteristics

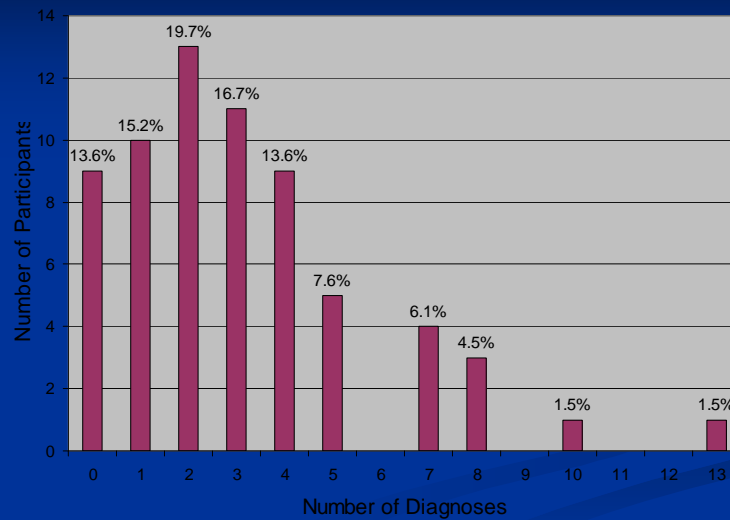
	EUC (n = 31)	ABFT (n = 35)
Age, Mean (SD), y	15.29 (1.83)	15.11 (1.41)
AA race, No. (%)	24 (77.4)	25 (71.4)
Female sex, No. (%)	23 (74.2)	32 (91.4)
Income, less than \$30,000 yearly income, No. (%)	13 (44.8)	14 (43.8)
Parent is high-school graduate, No. (%)	21 (84.0)	26 (78.8)
Single-parent household, No. (%) [‡]	6 (20.0)	19 (54.3)
Siblings living in home, Mean (SD)	1.79 (1.75)	1.52 (1.37)
Social Services involvement, No. (%)	13 (43.3)	12 (34.3)

[‡] $p = .006$

Clinical Characteristics

	EUC (n = 31)	ABFT (n = 35)
Suicide Ideation Questionnaire—JR, Mean (SD)	49.90 (13.53)	52.11 (13.42)
Beck Depression Inventory—II, Mean (SD)	23.19 (7.11)	24.03 (7.02)
Scale for Suicidal Ideation Past Week, Binary, No. (%)	25 (80.6)	30 (85.7)
Scale for Suicidal Ideation Most Severe, Binary, No. (%)	31 (100)	34 (97.1)

Number of Current Psychiatric Diagnoses



Clinical History

	EUC (n = 31)	ABFT (n = 35)
Adolescent attempted suicide in the past, No. (%)	19 (61.3)	22 (62.9)
Multiple attempts ^[1]	12 (63.2)	18 (81.8)
Adolescent past psychiatric hospitalization	7 (24.1)	7 (20.0)
Adolescent currently taking antidepressant medicine	3 (10.3)	3 (8.6)
Family history of suicide attempt	10 (34.3)	10 (30.3)
Parent history of suicide attempt	6 (60.0)	5 (50.0)
Family history of death by suicide ^[2]	5 (16.1)	5 (14.3)

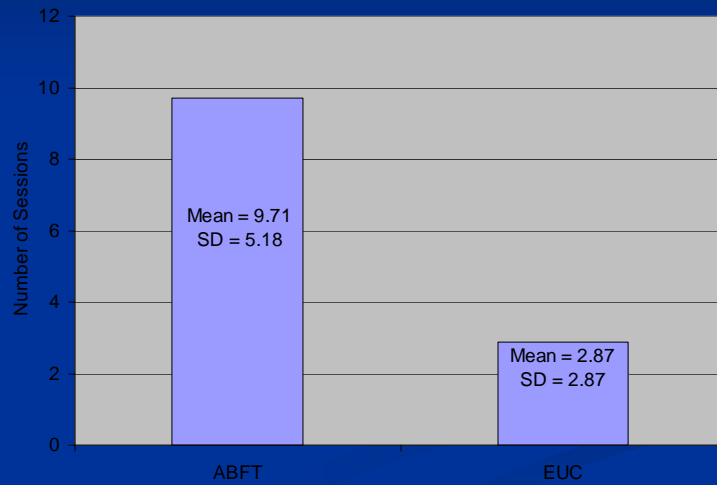
^[1] Of those with history of attempt
^[2] None were deaths of parents

RFS Top 10 (out of 21) Most Frequently Endorsed Items

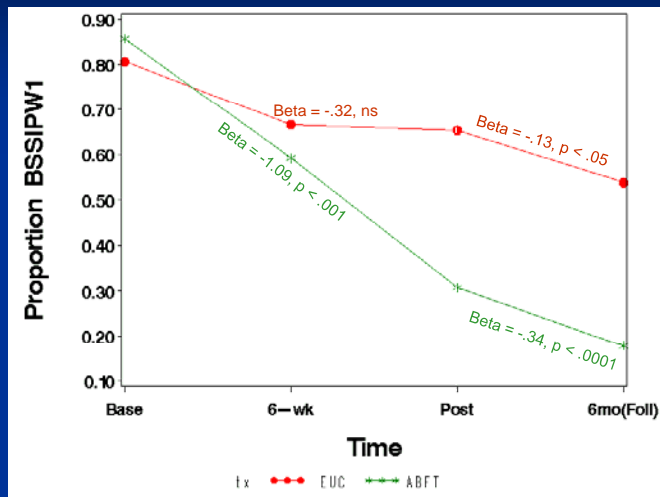
	n = 43 No. (%)
1. My parents don't understand me	31 (72.1)
2. Pressure to achieve	26 (60.5)
3. Loss of a family member	24 (55.8)
4. Overly controlling and/or critical parents	23 (54.8)
5. Poor grades	20 (46.5)
6. Feel like I didn't fit in	17 (40.5)
7. Loss of a close friend	17 (39.5)
7. Break-up with a boyfriend/girlfriend	17 (39.5)
9. Conflict with teachers or school administrators	13 (31.0)
10. My parents don't care about me	12 (29.3)

Rates of Retention

Mean Number of Sessions Attended

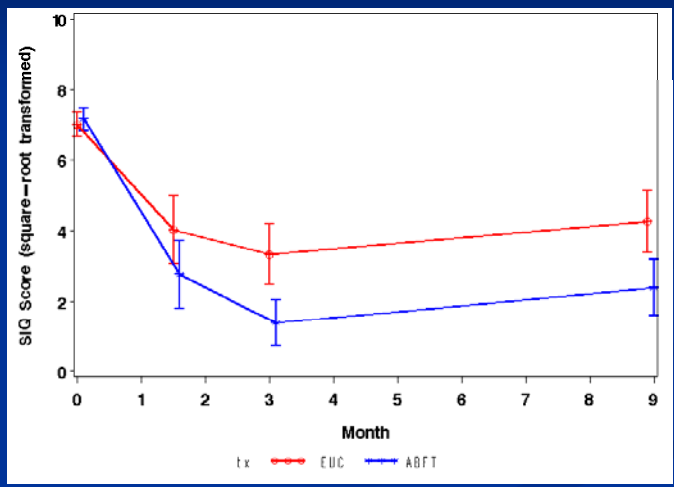


SSI Past Week

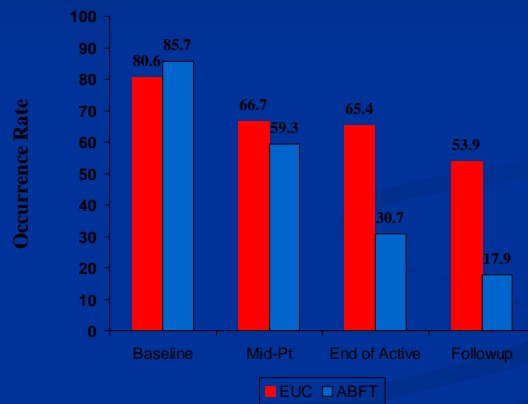


Active slope x Treatment Condition: Estimate = -.77, SE = .32, $t = -2.39$, $p < .05$

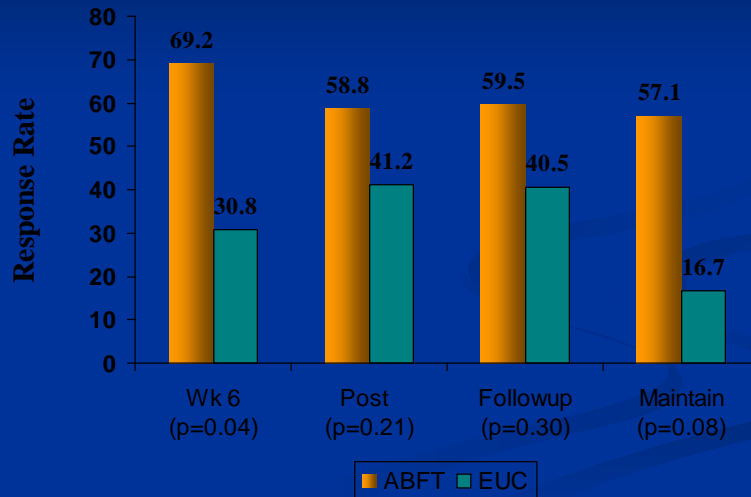
Follow-up slope x Treatment Condition: NS



SSI past week



BDI Response, 50% Reduction from Baseline



BDI, Proportion below 9

