Attachment-Based Family Therapy (ABFT)

Attachment-Based Family Therapy (ABFT) is a treatment for adolescents ages 12-18 that is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety. The model is based on an interpersonal theory of depression, which proposes that the quality of family relationships may precipitate, exacerbate, or prevent depression and suicidal ideation. In this model, ruptures in family relationships, such as those due to abandonment, neglect, or abuse or a harsh and negative parenting environment, influence the development of adolescent depression. Families with these attachment ruptures lack the normative secure base and safe haven context needed for an adolescent’s healthy development, including the development of emotion regulation and problem-solving skills. These adolescents may experience depression resulting from the attachment ruptures themselves or from their inability to turn to the family for support in the face of trauma outside the home. ABFT aims to strengthen or repair parent-adolescent attachment bonds and improve family communication. As the normative secure base is restored, parents become a resource to help the adolescent cope with stress, experience competency, and explore autonomy.

ABFT is typically delivered in 60- to 90-minute sessions conducted weekly for 12-16 weeks. Treatment follows a semistructured protocol consisting of five sequential therapy tasks, each of which has clearly outlined processes and goals:

- The Relational Reframe Task, with the adolescent and parents (or parent) together, sets the foundation of the therapy. After an assessment of the history and nature of the depression, the therapist focuses on relational ruptures. This shift pivots on the therapeutic question, “When you feel so depressed or suicidal, why don’t you go to your parents for help?” The progression of this conversation leads parents and the adolescent to agree that improving the quality of their relationship would be a good starting point for treatment.
- The Adolescent Alliance Task, with the adolescent alone, identifies relational ruptures in the family and links them to the depression. The adolescent is encouraged and prepared to discuss these often avoided feelings and memories with his or her parents.
- The Parent Alliance Task, with the parents alone, explores their current stressors and their own history of attachment disappointments. These conversations activate parental caregiving instincts to behaviorally and emotionally protect their child, which helps motivate parents to learn and use new attachment-promoting parenting skills.
- The Attachment Task, with the adolescent and parents together, creates an opportunity for the adolescent to directly express his or her thoughts and feelings about past and current relational injustices. Rather than defending themselves, parents help the adolescent fully express and explore these emotionally charged topics. This conversation helps the adolescent work through trauma, address negative patterns in the relationship, and practice new conflict resolution and emotion regulation skills.
- The Autonomy Task, with the adolescent and parents together, helps consolidate the new secure base. In solving day-to-day problems, parents provide support and expectations and the adolescent seeks to develop autonomy while remaining appropriately attached to his or her parents.

ABFT is usually delivered by trained therapists with at least a master’s degree in one of a number of mental health disciplines.

Descriptive Information

<table>
<thead>
<tr>
<th>Areas of Interest</th>
<th>Mental health treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes Review Date: September 2012</td>
<td></td>
</tr>
</tbody>
</table>
| 1: Major depressive disorder  
2: Depression symptoms  
3: Suicidal ideation  
4: Anxiety symptoms  
5: Treatment session attendance |
| Outcome Categories Mental health  
Suicide  
Treatment/recovery |
| Ages 13-17 (Adolescent) |
| Genders Male  
Female |
Quality of Research
Review Date: September 2012

Documents Reviewed
The documents below were reviewed for Quality of Research. The research point of contact can provide information regarding the studies reviewed and the availability of additional materials, including those from more recent studies that may have been conducted.

Study 1

Study 2

Supplementary Materials


Association, New York, NY.


## Outcomes

### Outcome 1: Major depressive disorder

| Description of Measures | Major depressive disorder (by DSM-III-R criteria) was diagnosed using the Schedule for Affective Disorders and Schizophrenia for School-Age Children (Kiddie-SADS)--Present and Lifetime Version (K-SADS-PL). The K-SADS-PL is a clinician-administered, semistructured diagnostic interview designed to assess current and past episodes of psychopathology, including major depression, in children and adolescents according to DSM-III-R and DSM-IV criteria. Probes and objective criteria are provided to rate individual symptoms. The interviewer adjusts the probes to the developmental level of the child and uses language supplied by the parent and child when querying about specific symptoms. The majority of depressive symptoms are only rated for the current episode and past 2 weeks, and all other symptoms are only given lifetime ratings. Interviews were conducted by clinician interviewers who were blind to treatment conditions, and diagnostic decisions were made by consensus with a senior diagnostician. |
| Key Findings | In a randomized clinical trial (RCT), adolescents with major depressive disorder (by DSM-III-R criteria) referred to a hospital-based psychiatry clinic who had a parent or guardian willing to participate in treatment were randomly assigned to either an intervention group receiving 12 weeks of ABFT or a waitlist control group receiving minimal contact for 6 weeks. Minimal contact consisted of weekly 15-minute telephone calls used only to monitor potential clinical deterioration. (Control group participants subsequently received ABFT if major depressive disorder was still present, but they were not included in the analyses.) Assessments occurred at baseline, 6 weeks after baseline (midtreatment for the intervention group and end of the waiting period for the control group), and 12 weeks after baseline (posttreatment for the intervention group). The percentage of adolescents no longer meeting the DSM-III-R criteria for major depressive disorder was higher in the ABFT group at 12 weeks than in the control group at 6 weeks (81% vs. 47%; p = .04). |

| Studies Measuring Outcome | Study 1 |
| Study Designs | Experimental |
| Quality of Research Rating | 3.1 (0.0-4.0 scale) |

### Outcome 2: Depression symptoms

| Description of Measures | In one study, depression symptoms were measured using two instruments: the Beck Depression Inventory (BDI), a 21-item self-report instrument that assesses the presence and severity of depression symptoms (by DSM-III-R criteria) during the past week using a 4-point scale, and the 24-item Hamilton Depression Rating Scale (HAM-D), a clinician-administered, semistructured interview that evaluates the presence and severity of depression symptoms during the prior week using a 3-, 4-, or 5-point scale. Higher total scores on the BDI and HAM-D indicate greater depression symptom severity. For the BDI, a subclinical level of depression symptoms was defined as a total score of 9 or less. |
| Key Findings | In an RCT, adolescents with major depressive disorder (by DSM-III-R criteria) referred to a hospital- |

In another study, depression symptoms were measured using the BDI-II, a 21-item self-report instrument that assesses the presence and severity of depression symptoms (by DSM-IV criteria) during the past 2 weeks. In contrast to the original BDI, this version includes items identifying symptoms of severe depression that would require hospitalization and uses a 7-point scale for measuring increases or decreases in sleep and appetite. Higher total scores on the BDI-II indicate greater depression symptom severity. A subclinical level of depression symptoms was defined as a total BDI-II score of 9 or less.
randomly assigned to either an intervention group receiving 12 weeks of ABFT or a waitlist control group receiving minimal contact for 6 weeks. Minimal contact consisted of weekly 15-minute telephone calls used only to monitor potential clinical deterioration. (Control group participants subsequently received ABFT if major depressive disorder was still present, but they were not included in the analyses.) Assessments occurred at baseline, 6 weeks after baseline (midtreatment for the intervention group and end of the waiting period for the control group), and 12 weeks after baseline (posttreatment for the intervention group). Findings included the following:

- At 6 weeks, the percentage of adolescents with a subclinical level of depression symptoms (as measured by the BDI) was higher in the ABFT group than the control group (56% vs. 19%; \( p = .03 \)).
- The percentage of adolescents with a subclinical level of depression symptoms (as measured by the BDI) was higher in the ABFT group at 12 weeks than in the control group at 6 weeks (62% vs. 19%; \( p = .01 \)).
- Adolescents in the ABFT group had less severe depression symptoms (as measured by the HAM-D) at 12 weeks than those in the control group had at 6 weeks (\( p = .005 \)), a finding associated with a large effect size (Cohen's \( d = 1.21 \)).

In another RCT, adolescents identified as being moderately depressed and having suicidal thoughts during routine clinical interviews in hospital-based primary care offices and the emergency room were referred to the hospital's psychiatry department. Those adolescents with confirmed depression and suicidality who had a parent or guardian willing to participate in treatment were randomly assigned to either a group receiving 12 weeks of ABFT or a group receiving 12 weeks of enhanced usual care, which consisted of a facilitated referral process with ongoing clinical monitoring. Adolescents in both conditions received weekly monitoring and access to a 24-hour crisis phone number. Assessments occurred at baseline and 6 weeks (midtreatment), 12 weeks (posttreatment), and 24 weeks (3 months posttreatment) after baseline. Findings included the following:

- At 6 weeks, the percentage of adolescents with a subclinical level of depression symptoms (as measured by the BDI-II) was higher in the ABFT group than the control group (34.4% vs. 11.1%; \( p = .04 \)), with ABFT adolescent participants being more than 4 times as likely as their control group counterparts to have a subclinical level of depression symptoms. This finding is associated with a medium effect size (odds ratio = 4.19). The difference between groups was no longer significant at 12 or 24 weeks.

### Studies Measuring Outcome

<table>
<thead>
<tr>
<th>Study Designs</th>
<th>Quality of Research Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experimental</td>
<td>3.5 (0.0-4.0 scale)</td>
</tr>
</tbody>
</table>

#### Outcome 3: Suicidal ideation

**Description of Measures**

Suicidal ideation was measured using two instruments, the self-report Suicidal Ideation Questionnaire (SIQ-JR) and the clinician-administered Scale for Suicide Ideation (SSI). The SIQ-JR is a 15-item instrument measuring the frequency of suicidal cognitions during the past month. Each item (e.g., "I thought about how others would feel if I killed myself," "I thought about how I would kill myself," "I thought that killing myself would solve my problems") is rated for the past month on a 7-point frequency scale ranging from 0 (I never had this thought) to 6 (almost every day). Individual ratings are summed for a total score of 0 to 90, with higher total scores indicating greater suicidal ideation. Clinical recovery was defined as a total SIQ-JR score of less than 13.

The SSI is a 19-item semistructured interview designed to assess the worst point of conscious suicidal intention over a specified time period. In the study, adolescents were asked to rate the worst point of their suicidal intention during the past week as well as in their lifetime (at baseline) or since the last assessment (at all other timepoints). Each item (e.g., "Wish to live," "Wish to die," "Reasons for living/dying") has three possible ratings reflecting intensity. For example, the ratings associated with the "Wish to live" item are 0 (moderate to strong), 1 (weak), and 2 (none); the same ratings are used with reverse scoring for the "Wish to die" item. Individual ratings are summed for a total score of 0 to 38, with higher scores reflecting greater suicidal intention. In the study, the total SSI score was dichotomized to indicate that suicidal intention was present (total SSI score > 0) or absent (SSI score = 0).

**Key Findings**

In an RCT, adolescents identified as being moderately depressed and having suicidal thoughts...
Adolescents in the ABFT group had a faster rate of improvement in suicidal ideation (as measured by the change in SIQ-JR score) than those in the control group from baseline to 12 weeks (p = .001). No statistically significant difference was found between ABFT and control group adolescents in the rate of change in suicidal ideation from 12 to 24 weeks.

The amount of change in suicidal ideation (as measured by the change in SIQ-JR score) was greater for adolescents in the ABFT group than those in the control group from baseline to 12 weeks (-5.32 vs. -3.35; p = .0007) and from baseline to 24 weeks (-4.37 vs. -2.34; p = .001). These group differences were associated with large effect sizes (Cohen's d = 0.95 and 0.97).

For the subgroup of adolescents who met DSM-IV criteria for clinical depression in the year prior to study entry, those in the ABFT group had a faster rate of improvement in suicidal ideation (as measured by the change in SIQ-JR score) than those in the control group from baseline to 12 weeks (p = .02). No statistically significant difference was found between these ABFT and control group adolescents in the rate of change in suicidal ideation from 12 to 24 weeks.

For the subgroup of adolescents who met DSM-IV criteria for clinical depression in the year prior to study entry, the amount of change in suicidal ideation (as measured by the change in SIQ-JR score) was greater for those in the ABFT group than those in the control group from baseline to 24 weeks (-4.35 vs. -2.19; p = .02). This group difference was associated with a large effect size (Cohen's d = 1.00).

Adolescents in the ABFT group had a faster rate of improvement in suicidal ideation (as measured by a change in SSI score to 0) than those in the control group from baseline to 12 weeks (p = .014) and from baseline to 24 weeks (p = .012). These group differences were associated with medium effect sizes (Cohen's d = 0.62 and 0.64).

A higher percentage of adolescents in the ABFT group than control group were in clinical recovery (as measured by the SIQ-JR at 6 weeks (69.7% vs. 40.7%; p = .02), 12 weeks (87.1% vs. 51.7%; p = .003), and 24 weeks (70.0% vs. 34.6%; p = .008). These group differences were associated with medium and large effect sizes (odds ratios = 3.35, 6.30, and 4.41).

A higher percentage of adolescents in the ABFT group than control group reported no suicidal ideation in the past week (as measured by an SSI score of 0) at 12 weeks (69.2% vs. 34.6%; p = .001) and 24 weeks (82.1% vs. 46.2%; p = .006). These group differences were associated with medium and large effect sizes (odds ratios = 4.25 and 5.37).

### Studies Measuring Outcome

<table>
<thead>
<tr>
<th>Studies Measuring Outcome</th>
<th>Study 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Designs</td>
<td>Experimental</td>
</tr>
<tr>
<td>Quality of Research Rating</td>
<td>3.6 (0.0-4.0 scale)</td>
</tr>
</tbody>
</table>

### Outcome 4: Anxiety symptoms

#### Description of Measures

Anxiety symptoms were measured using the dispositional (or trait) subscale of the State-Trait Anxiety Inventory for Children (STAIC). This subscale contains 20 statements about general anxiety that respondents rate on a 4-point scale ranging from 1 (not at all) to 4 (very much so). The STAIC includes a second 20-item subscale that measures current (or state) anxiety. Scores are calculated separately for the trait and state subscales, with higher scores on either subscale indicating a higher level of anxiety symptoms.

#### Key Findings

In an RCT, adolescents with major depressive disorder (by DSM-III-R criteria) referred to a hospital-based psychiatry clinic who had a parent or guardian willing to participate in treatment were randomly assigned to either an intervention group receiving 12 weeks of ABFT or a waitlist control group receiving minimal contact for 6 weeks. Minimal contact consisted of weekly 15-minute telephone calls used only to monitor potential clinical deterioration. (Control group participants subsequently received ABFT if major depressive disorder was still present, but they were not included in the analyses.) Assessments occurred at baseline, 6 weeks after baseline (midtreatment), 12 weeks after baseline (posttreatment for the control group), and 12 weeks after baseline (posttreatment for the intervention group). Adolescents in the ABFT group had less...
dispositional anxiety at 12 weeks than those in the control group had at 6 weeks (p = .007), a finding associated with a large effect size (Cohen's d = 1.24).

### Studies Measuring Outcome

**Study 1**

**Study Designs**
Experimental

**Quality of Research Rating**
3.1 (0.0-4.0 scale)

### Outcome 5: Treatment session attendance

**Description of Measures**
Treatment session attendance was measured as the self-reported number of sessions attended.

**Key Findings**
In an RCT, adolescents identified as being moderately depressed and having suicidal thoughts during routine clinical interviews in hospital-based primary care offices and the emergency room were referred to the hospital's psychiatry department. Those adolescents with confirmed depression and suicidality who had a parent or guardian willing to participate in treatment were randomly assigned to either a group receiving 12 weeks of ABFT or a group receiving 12 weeks of enhanced usual care, which consisted of a facilitated referral process with ongoing clinical monitoring. Adolescents in both conditions received weekly monitoring and access to a 24-hour crisis phone number. Assessments occurred at baseline and 6 weeks (mid-treatment), 12 weeks (post-treatment), and 24 weeks (3 months post-treatment) after baseline. During the 12 weeks of treatment, adolescents in the ABFT group attended more treatment sessions than their counterparts in the control group (9.71 vs. 2.87 sessions; p < .001).

**Study 2**

**Study Designs**
Experimental

**Quality of Research Rating**
3.1 (0.0-4.0 scale)

### Study Populations
The following populations were identified in the studies reviewed for Quality of Research.

<table>
<thead>
<tr>
<th>Study</th>
<th>Age</th>
<th>Gender</th>
<th>Race/Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study 1</td>
<td>13-17 (Adolescent)</td>
<td>78.1% Female, 21.9% Male</td>
<td>68.8% Black or African American, 31.3% White</td>
</tr>
<tr>
<td>Study 2</td>
<td>13-17 (Adolescent)</td>
<td>83.3% Female, 16.7% Male</td>
<td>74.2% Black or African American, 25.8% Race/ethnicity unspecified</td>
</tr>
</tbody>
</table>

### Quality of Research Ratings by Criteria (0.0-4.0 scale)

External reviewers independently evaluate the Quality of Research for an intervention's reported results using six criteria:

1. Reliability of measures
2. Validity of measures
3. Intervention fidelity
4. Missing data and attrition
5. Potential confounding variables
6. Appropriateness of analysis

For more information about these criteria and the meaning of the ratings, see [Quality of Research](#).
Study Strengths
All the clinical outcomes were measured using well-known instruments in the field with strong psychometric properties documented in the literature. The BDI, BDI-II, and HAM-D are considered gold standard measurements. In addition, the researchers provided study sample psychometrics for most of the measures used. Intervention fidelity was measured using a manual-driven fidelity adherence instrument—the Therapist Behavior Rating Scale (TBRS)—previously tested by the researchers and shown to have sufficient interrater reliability. Randomly selected videotapes of treatment sessions were rated by independent clinician-raters trained on the TBRS manual. The ratings, which had high interrater reliability, indicated that therapists implemented the intervention with fidelity. In one study, attrition was low in both conditions (11.4% and 16.1%), and there were no significant differences between the groups in completion rates at any assessment point. Both studies used a randomized study design to control for many potential confounding variables. Both studies used an intent-to-treat approach, and one study used sophisticated statistical modeling of the data that can handle low levels of missing data.

Study Weaknesses
No standardized service utilization instrument with known psychometric properties was used to measure treatment session attendance; this issue was most problematic for control group participants, who may have received any number of different treatments or none at all. In one study, there was high attrition in the intervention group (56%), and there was no description of missing data by outcome measure. Potential confounding variables in this study included the following: An unequal pre-to-post time period was used to assess the ABFT group (12 weeks) and the control group (6 weeks); the study sample size was small; and no assessment was conducted to determine whether the control group sought treatment elsewhere during the 6-week waiting period. In addition, there was no description as to how the high subject attrition and the missing data by outcome instrument were handled in the intent-to-treat data analyses, nor was there any analysis of the participants lost to attrition. Both studies may have had an inflated Type I error rate (i.e., identification of a significant relationship when one does not exist) due to the large number of comparisons made between the groups without a statistical correction.

Readiness for Dissemination
Review Date: September 2012

Materials Reviewed
The materials below were reviewed for Readiness for Dissemination. The implementation point of contact can provide information regarding implementation of the intervention and the availability of additional, updated, or new materials.

Behavioral Health Screen, http://www.bh-works.com


Readiness for Dissemination Ratings by Criteria (0.0-4.0 scale)
External reviewers independently evaluate the intervention’s Readiness for Dissemination using three criteria:

1. Availability of implementation materials
2. Availability of training and support resources
3. Availability of quality assurance procedures

For more information about these criteria and the meaning of the ratings, see Readiness for Dissemination.

<table>
<thead>
<tr>
<th>Implementation Materials</th>
<th>Training and Support Resources</th>
<th>Quality Assurance Procedures</th>
<th>Overall Rating</th>
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</thead>
<tbody>
<tr>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
<td>4.0</td>
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</tbody>
</table>

**Dissemination Strengths**
The starter packet provides detailed information about program requirements and criteria agencies can use to assess their implementation readiness. The treatment manual provides step-by-step guidance for therapists and supervisors for each of the therapy tasks in the model, and it describes the framework and rationale of the intervention, the session content, and the skills required for therapists in the treatment process. The introductory workshop uses a variety of teaching methods to present materials and engage participants. An advanced workshop, which provides ongoing support and additional skill development for therapists, is available. The therapist's adherence to and competency with the model are monitored through the supervisor's review of videotaped treatment sessions, which is followed by peer-to-peer supervision calls. The Web-based Behavioral Health Screen, an online assessment instrument, is accessed by clients at baseline and throughout treatment, and the data collected are automatically provided to therapists for use in assessing treatment outcomes and maximizing the quality of program implementation.

**Dissemination Weaknesses**
No weaknesses were identified by the reviewers.

**Costs**
The cost information below was provided by the developer. Although this cost information may have been updated by the developer since the time of review, it may not reflect the current costs or availability of items (including newly developed or discontinued items). The implementation point of contact can provide current information and discuss implementation requirements.

<table>
<thead>
<tr>
<th>Item Description</th>
<th>Cost</th>
<th>Required by Developer</th>
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<tbody>
<tr>
<td>Treatment manual</td>
<td>$69.95, or $49.95 for members of the American Psychological Association</td>
<td>Yes</td>
</tr>
<tr>
<td>Starter packet</td>
<td>Free</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavioral Health Screen</td>
<td>Contact the developer</td>
<td>No</td>
</tr>
<tr>
<td>1- to 3-day, on-site introductory workshop</td>
<td>Contact the developer</td>
<td>Yes</td>
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<tr>
<td>1- to 3-day, on-site advanced workshop (includes adherence checklists and competency measures)</td>
<td>Contact the developer</td>
<td>No</td>
</tr>
<tr>
<td>ABFT certification (includes 3-day introductory and advanced workshops, biweekly group supervision calls, video supervision and feedback, TBRS-3, adherence checklists, and competency measures)</td>
<td>Contact the developer</td>
<td>No</td>
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<tr>
<td>60- to 90-minute biweekly group supervision phone calls</td>
<td>Contact the developer</td>
<td>No</td>
</tr>
<tr>
<td>Video supervision and feedback</td>
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<td>No</td>
</tr>
<tr>
<td>Review of tapes for recertification (every 2 years)</td>
<td>Contact the developer</td>
<td>No</td>
</tr>
<tr>
<td>Telephone consultation</td>
<td>Contact the developer</td>
<td>No</td>
</tr>
</tbody>
</table>

**Additional Information**
Discounted rates are available for organizations that would like to use ABFT as part of a research study.

**Replications**
Selected citations are presented below. An asterisk indicates that the document was reviewed for Quality of Research.
To learn more about implementation, contact:
Suzanne A. Levy, Ph.D.
(215) 571-3415
slevy@drexel.edu

To learn more about research, contact:
Guy S. Diamond, Ph.D.
(215) 571-3420
guy.diamond@drexel.edu

Consider these Questions to Ask (PDF, 54KB) as you explore the possible use of this intervention.

Web Site(s):


This PDF was generated from http://nrepp.samhsa.gov/ViewIntervention.aspx?id=314 on 5/15/2014