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

Areas of Interest	Mental health treatment
Outcomes	**Review Date: September 2012** 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

Races/Ethnicities	Black or African American White Race/ethnicity unspecified
Settings	Outpatient
Geographic Locations	Urban Suburban
Implementation History	ABFT was first delivered in Philadelphia in 1996 as part of a clinical trial. Since then, it has been used in 16 different projects or agencies, reaching more than 500 families. The intervention has been implemented in Delaware, Massachusetts, Pennsylvania, and Virginia, as well as in Australia, Belgium, Israel, Norway, and Sweden. Within the United States, it has been evaluated in five controlled trials, with an additional study currently underway. Internationally, ABFT has been evaluated in Norway and Israel, with another study ongoing in Sweden.
NIH Funding/CER Studies	Partially/fully funded by National Institutes of Health: Yes Evaluated in comparative effectiveness research studies: Yes
Adaptations	An adaptation of ABFT has been developed for gay, lesbian, and bisexual adolescents. ABFT has been modified for use in Australia, Belgium, Israel, Norway, and Sweden. Program materials have been translated into Flemish, Norwegian (Nynorsk), and Swedish.
Adverse Effects	In the Diamond et al. (2010) study (see Documents Reviewed), four intervention group and seven usual care group participants made "low-lethality" suicide attempts. No adverse effects specific to the intervention have been found.
IOM Prevention Categories	IOM prevention categories are not applicable.

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

Diamond, G. S., Reis, B. F., Diamond, G. M., Siqueland, L., & Isaacs, L. (2002). Attachment-Based Family Therapy for depressed adolescents: A treatment development study. Journal of the American Academy of Child and Adolescent Psychiatry, 41(10), 1190-1196.

Study 2

Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., et al. (2010). Attachment-Based Family Therapy for adolescents with suicidal ideation: A randomized controlled trial. Journal of the American Academy of Child and Adolescent Psychiatry, 49(2), 122-131.

Supplementary Materials

Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The Scale for Suicide Ideation. Journal of Consulting and Clinical Psychology, 47(2), 343-352.

Diamond, G. M., Diamond, G. S., & Hogue, A. (2007). Attachment-Based Family Therapy: Adherence and differentiation. Journal of Marital and Family Therapy, 33(2), 177-191.

Diamond, G. M., Hogue, A. T., Diamond, G. S., & Siqueland, L. (1998, October). Scoring manual for the Therapist Behavior Rating Scale, 3rd version (TBRS-3).

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., et al. (1997). Schedule for Affective Disorders and Schizophrenia for School-Age Children--Present and Lifetime Version (K-SADS-PL): Initial reliability and validity data. Journal of the American Academy of Child and Adolescent Psychiatry, 36(7), 980-988.

Kirisci, L., & Clark, D. B. (1996, April). Reliability and validity of the State-Trait Anxiety Inventory for Children in an adolescent sample: Confirmatory factor analysis and item response theory. Paper presented at the Annual Meeting of the American Educational Research

Association, New York, NY.

Moran, G., & Diamond, G. (2008). Generating nonnegative attitudes among parents of depressed adolescents: The power of empathy, concern, and positive regard. Psychotherapy Research, 18(1), 97-107.

Moran, G., Diamond, G. M., & Diamond, G. S. (2005). The relational reframe and parents' problem constructions in Attachment-Based Family Therapy. Psychotherapy Research, 15(3), 226-235.

Reynolds, W. M., & Mazza, J. J. (1999). Assessment of suicidal ideation in inner-city children and young adolescents: Reliability and validity of the Suicidal Ideation Questionnaire-JR. School Psychology Review, 28(1), 17-30.

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. 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.
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 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	Study 1, Study 2
Study Designs	Experimental
Quality of Research Rating	3.5 (0.0-4.0 scale)

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

	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: • 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 = .01) 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	Study 2
Study Designs	Experimental
Quality of Research Rating	3.6 (0.0-4.0 scale)

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 for the intervention group and end of the waiting period 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 (midtreatment), 12 weeks (posttreatment), and 24 weeks (3 months posttreatment) 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; $p < .001$).
Studies Measuring Outcome	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.

Study	Age	Gender	Race / Ethnicity
Study 1	13-17 (Adolescent)	78.1% Female 21.9% Male	68.8% Black or African American 31.3% White
Study 2	13-17 (Adolescent)	83.3% Female 16.7% Male	74.2% Black or African American 25.8% Race/ethnicity unspecified

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.

Outcome	Reliability of Measures	Validity of Measures	Fidelity	Missing Data / Attrition	Confounding Variables	Data Analysis	Overall Rating
1: Major depressive disorder	3.8	4.0	3.8	1.8	2.3	3.0	**3.1**
2: Depression symptoms	4.0	4.0	3.8	2.8	3.0	3.3	**3.5**

3: Suicidal ideation	4.0	4.0	3.8	3.5	3.0	3.5	**3.6**
4: Anxiety symptoms	4.0	4.0	3.8	1.8	2.3	3.0	**3.1**
5: Treatment session attendance	2.3	2.8	3.8	3.5	3.0	3.5	**3.1**

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

Diamond, G. S., Diamond, G. M., & Levy, S. A. (2013). Attachment-Based Family Therapy for depressed adolescents. Washington, DC: American Psychological Association.

Diamond, G. S., & Levy, S. (n.d.). ABFT advanced training description and materials: Supervision workshop, group consultation, & video supervision. Philadelphia, PA: Authors.

Diamond, G. S., & Levy, S. (n.d.). ABFT dissemination and implementation: Starter packet. Philadelphia, PA: Authors.

Diamond, G. S., & Levy, S. (n.d.). ABFT quality assurance protocol. Philadelphia, PA: Authors.

Diamond, G. S., & Levy, S. (n.d.). Attachment Based Family Therapy (ABFT) introductory workshop participant guide. Philadelphia, PA: Authors.

Diamond, G. S., & Levy, S. (n.d.). Introductory training description and trainer documents. Philadelphia, PA: Authors.

Diamond, G. S., & Levy, S. (n.d.). Introductory workshop days 2 & 3 [PowerPoint slides]. Philadelphia, PA: Authors.

Program Facebook page, https://www.facebook.com/Attachment.Based.Family.Therapy

Program Web site, http://www.research.chop.edu/programs/cfis/abft.php

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.

Implementation Materials	Training and Support Resources	Quality Assurance Procedures	Overall Rating
4.0	4.0	4.0	**4.0**

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.

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

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.

Bosmans, G., Celis, H., & Vyvey, M. (in press). Depressieve Jongeren in Thuisbegeleiding binnen de Vlaamse Bijzondere Jeugdzorg: Kan Attachment Based Family Therapy een Meerwaarde Hebben? [Depressed youth in home guidance within Flemish youth care: Can Attachment Based Family Therapy contribute?]. Tijdschrift voor Orthopedagogiek, Kinderpsychiatrie en Klinische Kinderpsychologie.

Diamond, G. M., Diamond, G. S., Levy, S., Closs, C., Ladipo, T., & Siqueland, L. (2012). Attachment-Based Family Therapy for suicidal lesbian, gay, and bisexual adolescents: A treatment development study and open trial with preliminary findings. Psychotherapy, 49(1), 62-71.

* Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., et al. (2010). Attachment-Based Family Therapy for adolescents with suicidal ideation: A randomized controlled trial. Journal of the American Academy of Child and Adolescent Psychiatry, 49(2), 122-131.

Hermans, G. (2011, September). Attachment Based Family Therapy met depressieve adolescenten in de praktijk [Attachment Based Family Therapy with depressed adolescents in clinical practice]. In G. Bosmans (Chair), Gehechtheid en psychopathologie in de klinische praktijk: Nieuwe visies en methoden voor diagnostiek en behandeling [Attachment and psychopathology in clinical practice: New visions and methods for assessment and treatment]. Presented at the 8th Flemish Congress on Child and Youth Psychiatry and Psychotherapy, Leuven, Belgium.

Israel, P., & Diamond, G. S. (2012). Feasibility of Attachment Based Family Therapy for depressed clinic-referred Norwegian adolescents. Clinical Child Psychology and Psychiatry. Advance online publication.

Kobak, R., Diamond, G. S., & Grassetti, S. (2012, March). Attachment Based Family Therapy for suicidal adolescents: Who benefits the most? In R. Kobak (Chair), Attachment based treatments for adolescents: From symptom reduction toward a theory of change. Symposium conducted at the 14th Biennial Meeting of the Society for Research on Adolescence, Vancouver, Canada.

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

Web Site(s):

- **https://www.facebook.com/Attachment.Based.Family.Therapy**