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Promoting parental acceptance of bisexuality: A case study of attachment-based family therapy

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ABSTRACT

Attachment-based family therapy is an empirically supported, manualized treatment spanning over 15 years of research and clinical practice. Increasingly, research and clinical evidence emphasize the modification of family therapy models to meet the needs of diverse clients. Best practices require culturally-sensitive therapists to attend to issues of race, gender identity, sexual orientation, ethnicity, class, and ability. The ABFT model has been evolving to address the health disparities associated with marginalization and attend to the specialized needs of diverse families. This clinical case study demonstrates how ABFT clinicians must adopt an intersectional approach to be successful in building and sustaining relational repair. Transcripts from a case with a religious, African-American family and their bisexual daughter outline the structure and sequence of ABFT. An analysis of this case illustrates the impact of intersectionality on clinical processes and mechanisms of change.

KEYWORDS

Adolescents; attachment; bisexuality; family therapy

Introduction

Attachment-based family therapy (ABFT; Diamond, Diamond, & Levy, 2014) is a trust-based, emotion-focused treatment that is empirically supported and aims to repair interpersonal ruptures in parent/caregiver-child relationships. ABFT is designed to improve a family's capacity for affect regulation, interpersonal problem solving, and negotiation of attachment and autonomy. These improved capacities strengthen family cohesion creating a buffer against depression, suicidal thoughts, and risky behaviors (Garber, Robinson, & Valentiner, 1997; Restifo & Bögels, 2009). Once relationship ruptures are repaired, the later stages of treatment emphasize autonomy-building and identity development. ABFT was designed specifically to address adolescent depression, suicide, and trauma and has been adapted to be used with other populations. ABFT has evolved over 15 years of research evaluating its efficacy, effectiveness, processes, and mechanisms of change (Diamond, Russon, & Levy, 2016).

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There are no changes in affiliation subsequent to the time of this study.

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The ABFT Approach

Theoretical foundations

ABFT is rooted in attachment theory (Bowlby, 1988). Other approaches that have informed ABFT include: structural family therapy (Minuchin, 1974); multidimensional family therapy (Liddle et al., 2001); emotion-focused therapy (Greenberg, 2004); and contextual family therapy (Boszormenyi-Nagy & Spark, 1973). The core premise in the ABFT framework states that secure attachment relationships are marked by confidence in a caregiver's availability to provide support and protection (Bowlby, 1988; Kobak, Cassidy, Lyons-Ruth, & Ziv, 2006; Sroufe, 2005). Secure attachment enables direct, supportive communication between adolescents and parents that fosters perspective-taking, emotional regulation and development of competencies that protect against suicidal ideation and depression (Kobak et al., 2006). The presence of secure attachment solidifies an internal capacity to resolve conflicts cooperatively with caregivers, other adults (e.g., teachers), peers, and romantic partners. In contrast, a parent's unavailability and unresponsiveness may lead to negative expectancies for relationships, often characterized by disengagement, emotional dysregulation, conflict avoidance, aggression, and/or withdrawal (Kobak et al., 2006). Consequently, insecure attachment has repeatedly been associated with depression and suicidality in adolescents and adults (Kobak et al., 2006).

A negative family environment can compromise the attachment fabric. Clinically, adolescents often express attachment disappointments (e.g., abandonment, rejection) through daily conflictual interactions about behavioral issues (e.g., chores, curfews, and school). These stressful interactions with parents are most often associated with adolescents' depression, engagement in risky behavior, substance use, and unsafe sexual practices (Nock et al., 2008). 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).

The goal of ABFT is to promote security in the parent-child relationship, target current or prior ruptures in attachment security, and develop capacity for emotional attunement (Diamond, 2005; Diamond et al., 2010). Therapists accomplish these goals through systematic identification and repair of attachment ruptures (i.e., core family conflicts that get in the way of trust such as feeling criticized or being left alone when in need) and underlying attachment themes (i.e., core relational experiences that impact adolescents' views of themselves and others). Attachment themes are closely associated with vulnerable emotions such as sadness, fear, and disappointment (Diamond et al., 2014). Discussing these vulnerable feelings and associated attachment needs can create a corrective attachment experience for the family where adolescents turn to parents for support and parents provide comfort and

protection. Once this secure base is on the mend, family relationships help buffer against feelings of depression and suicidal ideation. 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). In adolescents, this expression of healthy attachment promotes self-esteem, emotional regulation, and positive peer relations.

Traditionally, ABFT was developed to treat depression and suicidality with a population of primarily low-income, African American families with adolescents (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Diamond, Siqueland, & Diamond, 2003). The model, however, has since been found to be clinically applicable for other mental health issues and populations. ABFT has been researched with: 1) young adults diagnosed with anxiety disorders in combination with Cognitive Behavior Therapy (Siqueland, Rynn, & Diamond, 2005); 2) young adults with unresolved anger toward parents, in combination with emotion-focused therapy (Diamond, Shahar, Sabo, & Tsvieli, 2016); and 3) families whose adolescents present with eating disorders (Wagner, Diamond, Levy, Russon, & Lister, 2016). ABFT has also been utilized with families from inner city, urban, and rural environments, as well as with adolescents who have diverse gender, sexual, racial, and cultural identities including immigrant families (Diamond et al., 2012; Diamond et al., 2003). ABFT has also been employed at clinical sites in other countries such as Australia, Canada, Belgium, Israel, Norway, and Sweden (Diamond, Shahar, Sabo, & Tsvieli, 2016; Diamond, Wagner, & Levy, 2016; Israel & Diamond, 2012; Ringborg, 2016; Santens et al., 2017; Santens, Devacht, Hermans, & Bosmans, 2016) with a variety of presenting mental health problems.

Structure of ABFT therapeutic tasks

The ABFT manual is focused on process and interpersonal relationships offering a structure and road map for facilitation of depth-oriented therapy in a 12- to 16-week period (Diamond et al., 2014). The model unfolds in five distinct, yet interrelated treatment tasks that focus on critical treatment processes summarized in Table 1. These five tasks serve as a guide for helping a family repair attachment ruptures and work toward increasing trust and security. These tasks are not the same as sessions; rather, each task identifies specific problems, procedures to address these problems, and outcome goals to help guide the therapist's decision making about what to focus on in a session. Therefore, while Task I is often a single session, the remaining four tasks vary in their number of sessions, to be determined by the need to accomplish specific task goals (Diamond et al., 2014).

Session participant composition also varies. Usually, the entire family is present during the Task I session where participants develop an initial

Table 1. Targets and mechanisms of change in the ABFT tasks.

ABFT Tasks	Session Numbers and Composition	Problem State	Expected Outcomes
Task I Relational Reframe	1 session, adolescent and primary caregivers are present	Parent criticism, individual view of adolescent depression/suicidal ideation	Reduce blame/increase mutual respect
Task II Adolescent Alliance- building	Usually 2–4 sessions with the adolescent alone	Low adolescent motivation, isolation, increased symptoms of depression and risk for suicidal behavior	Bonding, identifying attachment ruptures and needs, commitment to treatment.
Task III Parent Alliance- building	Usually 2–4 sessions	Parental stress, ineffective parenting	Intergenerational attachment history, promote emotional, authoritative parenting, emotional coaching
Task IV Repairing attachment	Usually 1–4 sessions, adolescent and primary caregivers present	Family disengagement, adolescent withdrawal/lack of emotional regulation	Addressing adolescent-caregiver attachment ruptures, rebuilding trust and dependability
Task V Promoting Autonomy	Varies by family, usually 3–4 sessions, siblings and extended family invited as applicable	Negative self-concept, interpersonal coping struggles	Increasing autonomy, interactive decision making

contract to work on their relationship to help the adolescent reduce levels of depression and/or suicidal ideation. During the Task II sessions, the adolescent meets with the therapist alone to discuss his/her depression/suicidal ideation history, attachment relationship with each parent, and prepares to talk with his/her parents about the attachment relationships. During the Task III sessions, the therapist meets with the parents/caregivers alone to uncover how their own life stressors and attachment histories have impacted their parenting approach to motivate them to work on their relationship and then prepare them to do so. The Task IV sessions bring the family back together with the therapist to initiate the attachment repairing process between caregivers and adolescents. Once trust between parents and adolescent is on the mend, the family continues to meet with the therapist in Task V sessions. In Task V, parents serve as the secure base to help the adolescent cope with issues driving their depression/suicidal ideation, help the adolescent get back on their appropriate developmental track, and address any additional concerns the family has raised. Individual sessions are sometimes held through the latter phase of therapy, with either parents and/or adolescents as needed, to support the goals of Tasks IV and V. Although the ABFT model provides a structure, treatment success depends highly on a therapist's capacity to build trusting relationships with each family member and to facilitate the interpersonal focus of the conversations creatively (Diamond et al., 2014).

Intersectionality and the ABFT model: Working with lesbian gay bisexual queer youth

Intersectionality provides a framework for understanding the multi-faceted complexities associated with multiple marginalized identities (Crenshaw, 1989). This theory encourages therapists and researchers to understand the collective impact of numerous identities on individuals, families, and societal systems. Instead of breaking down each identity separately, the experiences associated with marginalization can be layered and additive (Hancock, 2007). The ABFT framework encourages understanding how multiple systems of oppression can cumulatively impact the relationships among family members and mental health. The road to relationship repair in Task IV often requires both adolescents and parents to understand the internalized voices of oppression that are impacting their communication and ability to trust one another. Clinically, the relevance of these interventions has been demonstrated (Levy, Russon, & G.M. Diamond, 2016), and research has begun to support the use of ABFT with adolescents and young adults with multiple marginalized identities.

ABFT efficacy has been tested with Lesbian Gay Bisexual Queer (LGBQ) youth and young adults (Diamond et al., 2012; Diamond & Shpigel, 2014).

Because of multiple layers of stigma and oppression experienced, sexual minority youth are consistently at a higher risk for suicide than their heterosexual peers. Research has demonstrated that there are complex challenges associated with being LGBQ that may exacerbate depression and suicidality: increased conflicts in identity formation, discrimination faced in educational and work contexts as well as challenges faced in creating a secure sense of self, community, and belonging in relationships (King et al., 2008; Duncan & Hatzenbuehler, 2014; Marshal et al., 2011; Mustanski & Liu, 2013). LGBQ youth who have more family support, however, are less likely to report suicidal thoughts and attempts than those with less support (Hatzenbuehler, 2011; Mustanski & Liu, 2013; Ryan, Huebner, Diaz & Sanchez, 2009; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010).

The ABFT developers have taken a special interest in treatment development for LGBQ adolescents in the past decade and are currently working on research to support transgender, genderqueer, nonbinary, and gender non-conforming (gender diverse) youth and their families.¹ As such, ABFT is one of the few treatments to be modified and tested specifically for suicidal LGBQ adolescents and young adults (Diamond et al., 2012; Diamond & Shpigel, 2014; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). A recent pilot study adapted the ABFT model to suicidal and depressed LGBQ adolescents whose parents were aware of their sexual minority identification (Diamond et al., 2012). Results from this pilot project with 10 families demonstrated that the adaptations to the ABFT manual were successful in reducing depression and suicidal ideation in this population. ABFT is currently being implemented in a setting that provides care for trans and gender diverse youth experiencing depression and suicidality. The treatment approach and delivery is being modified to address the unique needs and psycho-social concerns for this population¹.

The LGBQ manual adaptations were developed according to the clinical needs of LGBQ youth. Session content became more focused on gender expression and sexuality. Diamond et al. (2012) found that parents needed more time in Task III ABFT sessions to work toward accepting their adolescent's sexual orientation while adolescents needed more time in Task II to discuss their gender expression and sexual preferences as well as the impact of living with their sexual minority identity, in social and educational contexts. To address LGBQ-specific parental concerns in these individual Task III sessions, therapists helped parents: a) process their emotions about their adolescent's sexual orientation and gender expression; b) understand their grief responses and reframe their assumptions; c) understand that acceptance is a process; and d) increase awareness of subtle, yet potent, invalidating

¹The project, titled Attachment-Based Family Therapy for LGBTQ suicidal youth: Feasibility, acceptability and transportability, is being funded by the American Foundation for Suicide Prevention, #PDF-0-124-15. PI: Jody Russon, PhD, LMFT.

responses to their adolescent's orientation (Diamond et al., 2012; Diamond, Russon, et al., 2016).

Adaptations of ABFT for LGBQ youth of color

Post initial ABFT research with LGBQ youth, therapists also became aware that there were likely several variations in mental health needs within this population resulting in a need to alter the therapy structure accordingly so as not to minimize within group differences. While some of the earlier modifications encapsulated the needs of gay and lesbian youth clients, the therapists realized that bisexual and transgender clients have unique needs in family therapy. This is especially true for immigrant populations and people of color living in the United States. The complex intersections of these identities require sensitivity, flexibility, and an understanding of systems of privilege and oppression on behalf of the therapist. For example, bisexual youth, especially those subjected to multiple sources of stigma, experience a unique set of obstacles in the context of parental relational repair.

Bisexual youth can often experience hostility or rejection from both heterosexual and lesbian and gay communities. Often, bisexual individuals are oversexualized or treated as though they are indecisive, in the media. Parents who are exposed to these messages often internalize them and engage in a process of self-blame and punitive communication. Assuming the normality of sexual and gender binaries, parents of bisexual youth may struggle to accept the permanency or legitimacy of their child's sexuality. In the context of repair work, this can make the process more complicated as the therapist must help the parent work through the confusion and uncertainty internalized from a binary society. From the experience of the youth, these factors may present as a lack of parental responsiveness and greater levels of rejection (Balsam & Mohr, 2007; Callis, 2013; Nguyen et al., 2016; Randazzo, Farmer, & Lamb, 2015; Ryan et al., 2010).

These parental "failures" experienced by bisexual youth may especially be true for families of color and for those living in poverty. The racism and classism experienced by these families already place them in a vulnerable position. Parents are worried about their children navigating a society that treats them as "lesser." Caregivers and parents of African-American young men are faced with the reality that their sons are often targeted by a biased justice system (Bobo & Thompson, 2006). Adolescents in poverty develop a sense of learned helplessness as they watch their parents struggle with the stress of making ends meet (Brown, Seyler, Knorr, Garnett & Laurenceau, 2016). For these families, having a bisexual child can bring up feelings of fear and self-blame for parents and caregivers, leading them to blame, reject and criticize their child. This dynamic is further complicated in families where

religion is a core source of strength and resilience and religious beliefs may come in conflict with their child's gender and/or sexual identity.

In keeping with these presenting features, modifications to ABFT when applicable include a greater amount of time processing the teen's identity and presenting concerns. Simultaneously, therapists can expect to work with parents to assess and offer support on their sense of loss, fear, and anxiety around individuals often described as "sexually confused" and who inhabit a space beyond sexual binaries. Prior research indicates that bisexual youth have expressed facing the stigma of bi-negativity and not belonging in either heterosexual or non-heterosexual groups, with a sense of felt pressure to conform to one group especially in gendered expression and in interpersonal relationships (Israel & Mohr, 2004; Rubinstein, Makov, & Sarel, 2013).

With an increased consciousness about the variations within this spectrum of gender and sexuality, we describe our clinical work with a bisexual youth and her religious parents using a clinical case example. Whilst we noted that an overhaul of the original model was not required, we became increasingly aware about changes in therapy content as well as therapeutic processes utilized. Specifically, we acknowledged the need to create a space for dialogue on sexual orientation and a slowing of therapy pace to address the lack of certainty for the family system and the mistrust and ambiguity that might be present in the therapy room.

Structure of the therapy tasks was also altered. As a result, in Task II, a greater amount of time was spent between therapist and adolescent discussing topics such as "What does being bisexual mean to you?" and "When did you discover non-heterosexual attraction and an interest in sexual behavior towards both sexes?" Intrapsychic meaning making occurred around these aspects (e.g., the identification of attraction towards girls in primary school and choosing gender neutral clothing preferences). Thus, in Task II, questions of sexual identity and exploring developmental trajectories accompanied the discussion around attachment ruptures and in preparing for Task IV. Even so, a great deal of trauma work or therapeutic process around identity conflicts was not conducted. Rather, individual sessions were conducted within the purview of family, social, and systemic contexts. In Task III with the parents, the concept of sexual fluidity was explored, wherein the therapist provided psycho-education, resources, and options for support groups to the parents. While much time in Task IV was spent processing the youths' attachment ruptures with both parents, there was also a focus on how these ruptures were rooted in parental rejection experience by the adolescent with regards to her sexual identity, gender expression, and dating preferences. The purpose was to increase trust and to thus facilitate more fruitful discussions in Task V.

Case Review

The case presented here describes the clinical model and an example of how the ABFT process unfolds across Tasks I through V with a Black, bisexual, cisgender female adolescent. This case seeks to exemplify how attachment theory guides the therapy process. The structure and sequence of this clinical model is reviewed along with examples of key mechanisms of change. The case study below highlights the different ABFT tasks and uses exemplary moments to elucidate the change mechanisms within each task. In addition to demonstrating the general model, the case profiles how a clinician might work with an African-American, bisexual adolescent and her family. The family consented to having their information represented in research and publications. Names and identifying information from the case have been changed to protect family identity.

Case history

Janice was a 15-year-old, African American adolescent who was referred for ABFT by her primary care practitioner due to significant suicidal ideation. She reported intermittent suicidal thoughts with no current intent or plan. She also reported symptoms of comorbid depression and anxiety as well as some social withdrawal. Janice was in the 10th grade and identified as bisexual. She lived with her mother Marcy (age 34), her father, Robert (age 36), and her sister, Sasha (age 8). The family identified as Catholic in their religious views and practice. They were well supported at the time of treatment with an emotionally and geographically close extended family network and strong connections to their community. Both paternal and maternal grandmothers were closely involved in the day-to-day functioning of the family, while both grandfathers had been absent or passed away. Ten years earlier, Robert had experienced some serious medical problems that inhibited him from returning to work. At the time of therapy, he was a stay-at-home father and engaged in some temporary work. Marcy had her master's degree in the mental health field and was the director of a local nonprofit agency.

Janice reported a history of suicidal behavior that originated when she was 10 years old. Her peers began to bully her because of her dark skin and natty hair. The bullying worsened when she gave a Valentine's Day card to a girl, and she started to display a more masculine appearance in her dress and mannerisms. This was particularly problematic in the Catholic schools she attended. Not wanting to burden or disappoint her parents, she tried to cope with these problems on her own but found that this led to tension with her parents who found her stubborn or disengaged. Janice began to withdraw inward to cope with these feelings, and, in turn, her mother and father began to worry about her health, academics, and life decisions. After being bullied

severely in school, she made her first suicide attempt; she tried to hang herself. Four years later, she attempted suicide again; she slit her wrists when her parents found out she was dating a boy. At the time of therapy, she reported that she experienced passive suicidal ideation quite frequently and had recently been prescribed anti-anxiety medication.

The ABFT therapy team

There were two ABFT therapists working on this case within a free ABFT outpatient clinic at a university. The clinic specialized in working with depressed and suicidal adolescents. The lead therapist was an ABFT trainee, who identified as a Brown, gender non-conforming, Muslim person in the late 20s from India. This was the second ABFT case for the therapist. The second therapist, the trainee's mentor, was an experienced ABFT practitioner who identified as a middle-aged, White, Jewish, heterosexual male. Cotherapy is often used in this clinic in the early training phases to: (1) help manage the severity of suicidal cases; (2) make the training experience more collaborative and transparent; and (3) accelerate the trainee's experience of generating and facilitating conversations about attachment and trauma. The lead therapist conducted the majority of individual sessions with the adolescent and her parents. The second therapist joined in a few of the individual sessions with the parents. Both the lead and second therapists met with the family together — in joint sessions with the parent(s) and the adolescent.

Description of the ABFT therapy process

Task I — Relational reframe

Task I sets the foundation for treatment by shifting a family's focus from "fixing" the adolescent to improving family relationships (Siqueland et al., 2005). The relational reframe is completed with the identified patient and parent(s) or primary caregiver(s) in one session, typically the first therapy session. After some general joining with the family and an adequate exploration of the history of the presenting problem, the therapist intentionally shifts the focus from symptom assessment to evaluation of the quality of relationships. The therapist guides the family into a discussion of what has gotten in the way of the adolescent turning to their parent for support in times of distress. These problems are identified as having ruptured trust. The goal at this phase of therapy is not to resolve these issues but rather to obtain sufficient information to identify their consequences on the parent-child relationship. Discussing the consequences of the disruption in the relationship allows the therapist to amplify both the parents' and adolescent's longing for improved relationships. With this longing for relationships shaping

the conversation, the therapist can reframe the goal of therapy from problem solving or fixing the adolescent to repair of relationships.

In the case with Janice, the therapists began Task I by exploring family strengths, Janice's current suicidal impulses, treatment history, and school functioning. The therapists explored Janice's history of depression, which she attributed to her experiences of being bullied for being "too black." Her parents had been aware of this discrimination and were adamant with the school to address this. Simultaneously, Janice was facing stigmatic comments from her peers for her gender expression and overtly "non-girlish" behavior. While her mom reported having had several talks with Janice about racism and discrimination to try and put these experiences into a more historical and political context, Janice had not shared with her mother the entire content of her bullying experiences, for fear of disappointing her. Thus, while Janice felt these conversations with her Mom were helpful in her understanding of her experiences at school, the bullying experiences and Janice's experiences of social isolation continued.

This kind of internalized racism can have an insidious effect in the Black community creating a pervasive feeling of Black inferiority, also referred to as the "black shadow" (Watson, 2013). The parents knew that Janice was struggling with the "triple jeopardy" of minority stress, racism, and heterosexism; however, they felt limited in the support they could offer her (Bowleg, Huang, Brooks, Black, & Burkholder, 2003; Greene & Boyd-Franklin, 1996). Eventually, Janice's parents moved her to a new school — a change that halted the bullying experiences. Unfortunately, this also led to a loss of a familiar social network and resulted in more isolation. This phase of the family's struggles in coping peaked when at age 10 Janice made a suicide attempt that required hospitalization. She eventually found a sense of community and greater peer support some years later when she moved to a performing arts high school.

Janice reported that she did not tell her parents about being bullied about her gender expression in elementary and middle school. Her parents had suspected her non-heterosexual orientation. Janice knew that her parents had read her personal diary and followed her friends on social media; however, they had never directly discussed her sexuality. When asked about this in the first session, the parents said they had assumed this was a phase and that she was just "sorting herself out." They pointed to her having dated boys as evidence that she was not gay. The therapist sensed the tension in this topic and suggested that they revisit it later. During the exploration of the presenting problem, it became clear that Janice's parents, Marcy and Robert, had conflicting parenting styles. Marcy was much more involved; however, Janice experienced her as somewhat critical and rigid. Robert was described as "more laid back," and this would often show up to Janice as his being indifferent and permissive. Janice's father seemed a bit more curious about

her sexual orientation, while her mother hardly wanted to consider the topic. These parenting differences had inhibited the parents from working well as a team to address the challenges their daughter faced.

Approximately 45 minutes into the session, the therapist shifted to the core reframing intervention. Turning to Janice, the therapist asked, “In your worst moments, when you are feeling isolated, sad and alone, what gets in the way of you going to your parents to tell them how you feel?” This was the intentional shift from behavioral and emotional problems to relationship problems. With some permission (and curiosity) from the parents, she began to describe her fears of parental criticism and rejection. She indicated that her mother, Marcy, would become harsh and punitive, and her father, Robert, would “throw up his hands” and say “she would just have to grow out of it.” Helping the parents to suspend their impulse to be defensive, the therapist redirected them to the consequence of their daughter’s feelings. The therapist said to Marcy, “I know this feels like criticism, and we will address that. But for now, I wonder if your feelings are hurt – hurt that she did not come to you for help? That must be disappointing.”

In this way, the relational reframe strategy does not focus on who is right or on resolving these differences. Instead, the therapist focused on the emotional/relational consequences of their problems. The therapist said, “You know, it is really tragic. It is clear that you love each other very much, and you have come through some hard times and raised two wonderful children. But I get the feeling that people feel lonely in the family. Marcy and Robert, your differences have led to arguments rather than compromise, and Janice you fear reprisal and rejection if you are honest with your parents about who you are (*long pause*)... I wonder if you would like to begin changing that?” In this vulnerable moment, the parents were able to admit that they felt at a loss about how to help their daughter. Janice agreed that she felt isolated, and alone, but also hopeless that things could change. With these sad feelings and longing for love in the room, the therapists were able to offer relational repair (e.g., “Can our first therapy goal be making this team stronger?”). Janice and her parents all tentatively agreed to working on the relationship first.

Task II — Adolescent alliance-building

Task II 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 gathers information about the adolescents’ life, values, and emerging identity. The therapist then helps an adolescent articulate his or her depression and suicide narrative (e.g., events, triggers, thoughts, and feelings). When appropriate, the therapist focuses on how parent-adolescent ruptures have inhibited trust in his or her relationships with the parents. Developing an attachment rupture narrative helps the

adolescent develop a more coherent and emotionally vulnerable/accurate story about their relationship disappointments and how they contribute to feelings of depression and thoughts of suicide. As the adolescent begins to understand these connections more clearly, the therapist introduces the idea of discussing these ruptures with his or her parents. Once the adolescent agrees to this task, the therapist prepares him or her to discuss these issues during Task IV. During Task II, alliance-building with the adolescent, the therapist serves as a secure base for the adolescent as he or she learns to articulate his or her attachment narrative in a more emotionally regulated and episodic way.

Janice's background. In this case, the therapist spent the first of four Task II sessions getting to know more about Janice's personal strengths, hobbies, and relationships with her peers. They began to explore her sexual identity and her experience as a bisexual person. She called herself an "old soul," with an interest in vintage movies and fashion. At the performing arts high school, she felt she had finally found a social group that would accept her bisexual identity. The therapist was interested in exploring her multiple identities as a Black, bisexual, Catholic, adolescent girl. To increase the likelihood of safety and create a sense of acceptance for the adolescent, the therapist offered own sociocultural location. The therapist said, "I do not know your experience of being a Black, bisexual woman, and I hope you will help me understand this better. I identify as a Brown, gender non-conforming person from a minority community and may resonate with some of your experiences, but I will not assume they are the same as yours, and I would like you to correct me when I do not understand your experience correctly." This statement helped create an opportunity to discuss race and culture in the therapy setting, thus building a stronger alliance with Janice.

In the second Task II session, Janice talked more about how bullying had contributed to her depression. Janice said she had felt different from other kids since kindergarten. She recounted how in fourth grade, she gave a girl a Valentine's Day card, and since then, she has been bullied for being "gay." She was simultaneously being bullied for her dark skin tone and natural hair. When her parents found out about the racial discrimination, they became eager to address this. However, Janice felt her mother's style of being helpful was to be critical and controlling (e.g., emphasizing that Janice should be stronger and embrace her cultural roots while refusing to give in to expensive hair treatments or extensions), while her father tended to minimize problems, telling her to be patient that it would be a "passing phase." As a result, she worried that they would perceive her as weak or force her to "snitch" on her peers if they turned to them for help. Eventually, her parents were helpful with the racial discrimination she faced (e.g., confronting the school, talking with her about racism, watching some movies together about

discrimination). Given her parents' strong religious affiliation, however, she felt that talking with them about her bisexuality would only cause trouble. Unable to turn to anyone for help, she internalized her feelings, began to feel more anxious and depressed, and experimented with marijuana.

Review of relational ruptures. Janice felt as though her parents did not provide care, support, and protection when she had an attachment need. Janice found that her parents initially denied her request for help (e.g., when she complained about being bullied), minimized her experiences (e.g., convinced her that she had gone "a bit astray" in terms of her sexuality), and finally rushed to problem solving when the bullying persisted instead of trying to understand (e.g., wanting to complain to school authorities about her being bullied rather than asking her what it was about). As a result, Janice started to experience a lot of guilt about being a disappointment to them and experienced increased anxiety that resulted in her tending to her own needs and relying less on her parents for comfort. She began to expect and fear her parent's rejection, thus developing what appeared to be an *avoidant attachment style*. As a result, she found herself feeling abandoned, isolated, alone, and rejected for her bisexual identity. Furthermore, Janice perceived herself as a burden on her parents, which increased her reluctance to confide in them about her troubles.

Identifying Janice's attachment narrative. In the third Task II session, the therapist explored the use of metaphor to help Janice conceptualize her experience. The therapist compared her experience to a jar where she stored her difficult feelings. She would add to the jar and then put a lid on it; when the jar got full and started to rattle, coping became more difficult for her. She would suppress these emotions, causing her to become anxious or impulsive and self-harming. Much of the third and fourth Task II sessions were spent helping Janice uncover her attachment narrative, processing secondary emotions of frustration and anger, as well as the more vulnerable primary emotions such as hurt and disappointment. Janice expressed that for much of her life, her attachment needs for parental protection and care were not met, leading to an internal working model that she was unworthy of love and people were unreliable and unpredictable.

Janice also began to talk more about being bisexual. She described the lack of support from family, peers, or her church community around this topic and the pain its impact had on her. Her parents were somewhat aware of her struggles ignoring them and hoping they would pass. Robert vacillated between tolerance and rejection by saying "she can be anyone she wants when she moves out of the house." The therapist helped Janice talk about how these comments made her feel and aspects she was and was not willing to tolerate in her parents' reactions to her sexual identity. Challenging the

mask of indifference and with tears in her eyes, Janice vocalized that she knew her parents would never fully accept her bisexual identity, but she still wanted a close relationship with them. Janice admitted that she had never directly discussed her sexual identity with them, as she assumed it would only lead to conflict. She only hoped that when she got older, they would be more tolerant.

The therapist explored with Janice the burden she carried by not speaking up for herself and how her feelings of rejection or denial contributed to increased depression and suicidal feelings. The therapist suggested that her parents may never accept her sexual orientation; however, she could expect them to stop denigrating her or ignoring others' attempts at doing the same. The therapist also suggested that standing up for herself was better than hurting herself. Janice found these comments both challenging and interesting. Her trepidation however remained, as she feared more rejection from her parents. The therapist discussed with her that parental acceptance would be a process for both her and her parents and that Janice was entitled to ask for more protection from them — protection from their own and others' insults. Eventually, Janice reluctantly agreed to talk with her parents about these felt injustices. The final Task II session focused on preparation for these conversations.

Task III — Parent alliance-building

Task III often occurs simultaneously with the Task II adolescent alliance-building sessions and also lasts between two and four sessions. Therapists meet with the parents alone and usually begin with exploring the parents' current stressors. The therapist helps the parents gain insight on how their stressors may be affecting their parenting behavior, thus reducing self-blame and guilt. The therapist also explores the parents' own history of attachment disappointments (Feder & Diamond, 2016). Once parents have empathy for their own attachment disappointments, they become more sensitive to their child's experience. This reactivates empathy for their child's experience and motivation to learn new parenting skills. The therapist can then teach parents some emotional coaching skills that can increase their listening and attunement skills (Gottman, 2001, 2011; Gottman, Katz, & Hooven, 1996, 1997).

The therapists met with Janice's parents, Marcy and Robert, for six sessions. Having additional parent sessions is common when treating LGBTQ youth in the context of ABFT. The first session with both parents explored their marriage, personal stressors, and triggers of marital distress. An important theme in their stories was Robert's illness; he had never fully recovered. This impacted his work capacity, self-esteem, and depression, and it contributed to a gambling addiction. During all of this, Marcy struggled to complete her master's degree, worked full time, and felt somewhat alone in raising their children. These problems also seriously impacted their trust and

marital intimacy and ruptured their parental team work. As a result, Robert and Marcy had begun to parent their children independently with no mutuality and teamwork, making Janice and her sister aware of their rift. Even in the face of these challenges, the couple had a strong commitment to their marriage and to their church community, a mutual activity that kept them bonded. The therapists praised their strengths and self-awareness and their ability to raise their two wonderful daughters despite these challenges. The conversation exposed gaps in their parenting styles, and they pledged to work on becoming a stronger parental unit.

Both therapists met with the parents during the second Task III session. They explored with Robert and Marcy their feelings about Janice's bisexual identity. Both Robert and Marcy identified themselves as strongly religious and attended a church that frequently made disparaging comments about "homosexual" people. Marcy stated strongly that,

"In my opinion, Janice's identity as a bisexual person has only been confirmed after she entered this performing arts high school. There is a big community of youth who identify as LGBTQ there, and they encourage her to be like them."

These conversations explored the mother's denial of her daughter's sexual identity and free will. It also exposed the inherent conflict between her religious beliefs about heterosexuality being the moral choice for her and her children, along with her worries about her daughter's well-being. Robert had suspected for some time that his daughter was not heterosexual. He expressed both tolerance and ambivalence. He stated, "She can be whoever she wants, but not in my house." The therapists helped the father reflect on how this stance could impact his relationship with his daughter creating an emotional distance in their relationship and exacerbating her depressive symptoms and risk for self-harm. The therapists assured the parents that they were not trying to change their minds about Janice's sexuality, rather that they felt that the family needed to have more direct conversations about this complicated topic. The parents agreed to this goal.

The therapists recognized that pushing these parents toward full acceptance would compromise the alliance. Instead, they strove to meet the parents where they were with a request to continue exploring their feelings about their daughter's sexual identity. A deliberate shift to each parent's attachment history was needed in order to help parents soften toward their daughter's current experiences and change their perceptions surrounding her behaviors. The therapists had anticipated that from this softer emotional stance, they could revisit the daughter's sexuality. The therapists decided to meet with each parent in separate sessions to explore their individual attachment history. This strategy served to minimize the marital conflict impacting each parent's ability to be honest and vulnerable.

In the next Task III session, the therapist met alone with Marcy. After providing some support for her current frustrations with her husband, the therapist explored her attachment history. Marcy reported a childhood filled with chaos and abuse. Her mother was a teen parent of four children, and there were many men living in the home at different times. At age 16, one of the men sexually molested Marcy. When she reported this to her mother, her mother did not believe her. This was a turning point for Marcy; she stopped hoping for maternal love and protection and turned to grandparents and the church for comfort and safety. With the therapist's help, Marcy acknowledged that her anxious and controlling parenting style partially stemmed from her desperate desire to protect her daughter from the life she had lived. She could also recognize that being "overbearing" with her religious values that had been such a strong resource for her; she was pushing her daughter away. Despite Marcy's best efforts, she recognized that Janice felt isolated, alone, and unprotected, the same way Marcy had felt as a child. These revelations renewed her interest in learning some new parenting skills and being a different kind of parent.

In a separate session, both therapists met with Robert. He disclosed that his childhood was also filled with domestic violence. He survived by withdrawing from his family and having very low expectations of love and support from his parents. This left him feeling isolated and independent. Since then, he had reconciled with his parents in his 20's, and he now felt them to be positive resources in his life. With help from the therapists, he recognized how his indifferent parenting style grew out of his low expectations of love from family. He recognized that his ability to withdraw into indifference left Janice feeling unsure of his love, commitment, or availability. Robert came to see that his own fears of rejection were in fact serving to replicate that same experience for his wife and daughters.

These two individual sessions created a better bond between the parents and the therapists. The conversations also intensified the parents' motivation to try to be different for each other and to be better parents. With that motivation in place, Robert and Marcy became more receptive to learning emotion-focused parenting skills. The parents learned how to listen without fixing and to show empathy and curiosity without judgment. These skills were expected to help Robert and Marcy listen to their daughter's experiences regarding her bisexual orientation.

In terms of the content of the discussion, ABFT often takes an active stance in generating discussions about sexual identity and sexuality when working with sexual minority youth and their parents (Diamond et al., 2012; Diamond et al., 2016). Therefore, in preparation for this discussion, Marcy and Robert were encouraged to discuss as a couple their limits and their tolerance for their daughter's identity as a bisexual woman. This included a discussion of the difference between acceptance and tolerance, particularly

not saying harmful things to their daughter about her bisexual orientation. The therapists made use of the parents' intergenerational legacy of attachment ruptures to become more empathetic allies with their daughter — even if they could not accept her sexual orientation at this time based on their moral and religious sentiments. The therapists accepted their resistance and gently confronted them with the mental health and relational costs with their daughter if they could not reconcile their love for their daughter and their religious beliefs.

They eventually agreed to come to Task IV sessions and allow Janice to talk about her bisexual identity as well as the trauma she faced around it. If these conversations became emotionally overwhelming, they also agreed to support one another. At the therapists' request, both parents began to familiarize themselves with issues related to non-heterosexual identities. ABFT encourages parental psychoeducation around sexual orientation, and therapists provide parents with resources and support group options. With this in place, the parents were more prepared for Task IV.

Task IV — Repairing attachment

Task IV serves as a corrective attachment experience where adolescents share difficult and often painful stories, and the parent(s) provide empathy, understanding, and support. Task IV typically lasts between one and four sessions depending on the complexity and the amount of ruptures. The task begins with the adolescent disclosing previously unaddressed hurt, anger, or pain to his or her parent(s). These ruptures may include feelings or experiences involving betrayal, abuse, abandonment, neglect, or rejection. When extensive traumas are not present, the conversations usually focus on relational dynamics such as control, criticism, and over intrusiveness. The therapist coaches the parents to respond with empathy and support, thus encouraging the adolescent to continue to deepen his or her exploration of thoughts, memories, and feelings.

This extended conversation helps to resolve family wounds and conflicts: 1) giving the adolescent practice solving interpersonal problems; 2) teaching adolescents to tolerate and express vulnerable emotions; and 3) helping the family have positive experiences of working through difficult emotional challenges. 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. Adolescents can then start to see their parents as a resource, accept more parental guidance, and even develop a more appropriate perspective on parents as people with strengths and weakness, or what Fonagy would call, reflective functioning (Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Target, 1997).

For this family, both therapists conducted the four Task IV sessions during which Janice had a chance to express her attachment ruptures to

her parents. Janice had planned initially to discuss the relational ruptures with her parents resulting from the bullying experiences and her parents' initial lack of attention to this. If that went well, she indicated she would feel more confident about discussing her sexuality. Because of a minor car accident, her father was unable to attend the first Task IV session. As this session began, Janice discussed her disappointment that her parents did not protect her more from the bullying in elementary and middle school. The therapists encouraged Janice to speak up about her experiences asking her, "Can you tell your mom about why you did not go to her for help with the bullying?" Janice described how she worried that if she asked for help, that her mother would rush in to "fix" everything and not be attuned to Janice's experiences. Janice feared this would get her friends into trouble and exacerbate her victimization. She also feared that her parents would make her "bounce around to yet another school." For the first time, Janice told her mother that she (mother) seems to get overwhelmed with her own emotions and does not really pay attention to Janice's feelings and needs. She was also worried that if her parents found out that she was bullied because of her attraction to girls, they would be embarrassed by her and reject her.

Much to Janice's surprise, Marcy did not get defensive or critical. Throughout the session, Marcy was curious, empathetic, and validating toward Janice's experiences — skills she had learned in Task III. She even slid over on the couch to hold Janice's hand as Janice recounted these stories and fears. Marcy's receptivity made Janice teary-eyed, at which time Marcy slid closer and put her arm around her daughter. For the first time in years, Janice cried in her mother's arms; she was receiving the kind of comfort and protection she had wanted as a child. As Janice gained more confidence in herself and her mother, she felt more willing to discuss her sexuality. In the following session, the therapists helped Janice discuss this complicated topic with both parents. Janice began by reiterating that she felt this topic "was better avoided," but her parents reassured her that it was time to address it directly, even though it would not be easy. The therapists continued to coach Janice on telling her parents how their comments and behaviors indirectly expressed their disapproval of her. While many parents think these kinds of "macroaggressions" are incidental, these chronic behavioral actions can be hurtful and off-putting for an adolescent (Duncan & Hatzenbuehler, 2014). Janice started by saying that she knew that they were not happy about her sexual orientation and may never accept this about her. She went on to say she felt angry and hurt when they made derogatory comments about her gendered expression, sexual orientation, or about LGBTQ individuals in the media in general.

Caught off guard by her social advocacy stance, Janice's parents had to admire her desire to protest against the unfair treatment of individuals for being different or minority. Her parents, strong advocates against racial discrimination, felt proud that they had imparted their values to their daughter. Despite this, her mother stated that her religious values would never let her fully accept her daughter's sexual orientation but that she could agree with not being denigrating toward her daughter. The therapists empathized with the mother's dilemma of divided loyalties between the daughter she had borne and the church that had saved her life and marriage. In a profound tight-lipped statement, her mother stated, "I will always love you, but I will never accept this. I am not willing to compromise my values." Teary-eyed, Janice felt loved, but also rejected. It was the best the mother could offer at the time.

Task V — Promoting autonomy

Task V fosters the adolescent's healthy expression of self and development of autonomy. In this phase of family life, both the adolescent and the parent(s) become responsible for maintaining their attachment. With attachment on the mend and depression on the decline, parents can also begin supporting the development of autonomy. Task V typically involves five or more sessions where parent(s) and the adolescent tackle topics such as the adolescent's depression and suicidal ideation, social support systems, school problems, self-esteem, relationships, sexuality, and sibling concerns. Many families begin renegotiating the adolescent's responsibilities within the home, such as being more responsible about rules and chores and finding a more respectful and democratic way to address these developmental tasks. Families may also talk about identity issues such as religious beliefs, ethnicity, and gender and sexual identity.

Both therapists met with Janice and her parents during the Task V sessions. The first conversation focused on the church. Janice's parents sensed her decreasing interest in going to services and took this as one more sign of her general moral decline. Listening to this lecture, Janice began to withdraw from the conversations, her legs trembling with anxiety, her head buried in her hands. The younger therapist moved closer to her and encouraged her to speak up. "This is the time to be honest with your parents. I know this is hard, but they are listening." With this support, Janice sat up and began to describe the homophobia she experienced at the church. She said that kids at youth group were supportive, but that the minister at least once a month derided anyone who was non-heterosexual during his sermons. At first her mother minimized this, claiming that he was just preaching the scriptures. But her father spoke up and said, "Come on Marcy, if the minister was up there making racial slurs you would be livid. For Janice, this is just as personal to her."

Her mother was again caught between her love for her daughter and her love for the church; however, this time, rather than being tight-lipped, she became speechless. The therapist suggested that she was caught between feeling defeated and liberated. Robert put his hand on his wife's shoulder and said, "Come on Marcy, this is our daughter." After a long silence, Marcy turned to her daughter and, with great humility and conviction, asked for her help. She said, "I still cannot accept this, but I want to be on your side. I will not let anyone hurt you again. I want to understand how to help you and will do whatever I need to do." Although Marcy's tone was still a bit harsh, Janice felt her mother had turned a corner; her maternal instinct of love and protection was triumphing, not over her religious devotion, but over the church's moral injunction against homosexuality. Jokingly, she suggested she would start support group for other parents of LGBTQ youth.

Past research has suggested that religious faith plays an essential role in fostering positive mental health outcomes for the disenfranchised African-American community (Austin & Harris, 2010; Lincoln & Mamiya, 1990; Mattis & Jagers, 2001). However, studies have found that for LGBTQ youth, internalized homonegativity and spiritual discrimination creates a complicated picture of alienation, frustration, and guilt with religious faith (Walker & Longmire-Avital, 2013). Some of our own research suggests that while parents' and children's religious participation is a protective buffer for heterosexual suicidal youth, the opposite is true for non-heterosexual youth (Shearer et al., 2016). Receiving this support from her mother appeared to give Janice hope that her mother could help her find support from their church. The therapists praised Marcy for her gesture of love and understanding. Helping Janice listen below her mother's stern voice tone, the therapist helped Janice appreciate this gesture and tell her mother that (thus reinforcing her mother's new behavior). The therapists encouraged Marcy to move close and take her daughter's hand in an offer of solidarity and support, without any pressure to say anything.

In one of the Task V sessions, the conversation returned to sex. Her father continued to associate sexual orientation with sexual promiscuity. Parents often confuse "sexual orientation" with "having a lot of sex." Robert expressed that he feared his daughter was experimenting and being promiscuous. He said he could accept Janice's new sexual identity but was concerned for her safety. He feared that her public display of sexual identity (e.g., Facebook, Snapchat) might make her easy prey for men or women wanting to have sex with her. Janice was very offended and started to retreat during this session. The therapist redirected the conversation by using it as an opportunity to help Janice talk about her values and have her father serve as a sounding board. This helped Janice and her parents have normative conversations about sex, which resulted in Janice having more autonomy and

building a more mature relationship with her parents. The following exchange exemplifies this process:

Therapist 1: Janice, I think your father keeps mixing up your sexual interests with you having sex. Can you help him understand your thoughts on this?

Janice: The thing is, for me, it is important to have safe sex and not to sleep around. I don't plan on having sex with anyone. But I do feel I am ready to date – someone I know and trust. Mom and Dad feel like just because I date once, or that because I am bisexual, I am determined now to go on a rampage and have sex with anyone and even get myself pregnant or something!

Mother: I never said that, but I didn't want you dating, and you just went ahead and did it anyway.

Janice: And now Dad just thinks I am just a cheap slut!

Father: Well, if you do something rash, I'm going to call you out on it.

Therapist 2: I know this is a difficult topic for everyone. Mom, Dad, how about we try to understand Janice's thinking a bit more. See if you can help her think about these complicated decisions.

Janice: Ok. Well, I know I dated at 14, and you both told me I should wait until 16, but I had my reasons. (*Parents roll their eyes.*) Ugh. What's the point, you will never understand.

Therapist 1: (To Janice) Mom and Dad were hurt by you breaking the rules they set down for you about dating. You have to give them that, but let's not rehash that from 2 years ago. Janice, try to explain to them what is hard for you right now as you are making these decisions.

Janice: So, right now, I feel judged by you, like you don't trust me. I was vulnerable and sad that one time last summer when you caught me dating Steve. Even if I was dating a girl, I want you to know that I would take time to get to know her. I want to make better choices, but I don't think I can talk to you about this.

Mother: Well, I am just saying I don't want you to be hurt that way. I don't want you having casual sex with someone. I want you to respect your body; I am worried about you ... (*Mom pauses and catches herself preaching.*) Tell me more about the kind of person you want to date in the future.

Janice: I want them to be fun, but sensitive to my feelings and to enjoy things that I do.

Mother: Those are all great things. I also think that it's important for you to be compatible with them, that they respect you. I want

you to be able to talk with me about this. Maybe not all the details but at least what you are thinking about.

Janice: I guess I could talk to you about that a little . . . maybe . . . we're still a few steps away from that kind of trust (*chuckles*).

Therapist 2: Yes, it may take some time, but it might be a good idea to check in with one another once in a while. Mom, maybe you can try to find a good time occasionally to check in on her about how this is all going.

Janice: Yeah that sounds good. Then I can tell her if I'm ready.

Therapist 1: Can you also talk to Dad so he trusts you? I think he could stay more on your side if you do.

Janice: Um . . . well . . .

Therapist 2: Robert, would you like her to talk with you about this a bit.

Father: I want you to know I have your back Janice. I want you to feel more open with me again. Even when you're in trouble, I want you to be able to talk to me about things, rather than do anything rash or anything just because your friends are doing it.

Janice: Yeah, I know what you mean. I guess I'm just sometimes scared of your reaction if I'm spending time with a girl.

Father: I understand that. I am working on that, but for me, now, it's important that you're monitored. You are almost 16 and we said you could date at that age, but we still want to know about it. I could take you and your friend to the movies, or to get ice cream, or go on a drive if you would like that. That way I can get to know the person better.

Janice: Hmm. That might be nice, actually. I guess we could try that and see how it goes.

In this exchange, the therapists urged Janice to start negotiating what she will share and not share about her emerging young adult life. The therapists also helped the parents remain attuned, open, and supportive to avoid a shut-down of the conversation. Helping the parents shift from content (i.e., sexual exploits) to process (i.e., creating a space for trust and sharing) was helpful in maintaining an open conversation. The primary goal was to help Janice be reflective about her life and to use her parents as a secure base for her emerging autonomy. Other topics that were discussed included school performance, summer work, and how and if Janice should continue at the church. Attachment theorists refer to this as a "goal corrected" partnership where both sides are invested in maintaining the relationship and thus more willing to enter into a "give and take" relationship (Bowlby, 1988; Cassidy & Shaver, 1999; Waters & Cummings, 2000).

By the end of treatment, Janice's parents expressed that they felt more confident about her ability to make good choices. They all felt better able to negotiate Janice's emerging young adult identity, even though there were still difficult issues to explore and resolve. The couple was referred to marital therapy to work on their relationship and to relieve Janice from worrying about the stability of her family. Janice's depression had begun to remit, and her thoughts of suicide had subsided.

Conclusion

The sequential nature of the five ABFT tasks is important to facilitate conversations between the parent-child family systems as well as to address the unique needs of the subsystem (couple relationship). These alliance-building conversations with adolescents and their parents in Tasks II and III, respectively, serve as content and emotional material for the restructuring that occurs in Tasks IV and V with the family unit. In certain circumstances, when parental availability is limited, others (e.g., grandparents, siblings, extended family) are invited into the family sessions.

With this case, the intersectionality of race, sexual orientation, and religion required the therapist to be well versed in the influence of wider systems of privilege and oppression. The study of cultural identity and self of the therapist helps prepare therapists for these kinds of conversations (Aponte and Kissil, 2016; McGoldrick & Hardy, 2008). The general ABFT framework, however, suggests that until relational ruptures are repaired and interpersonal trust is on the mend, addressing these more complicated topics may not feel safe for family members, particularly the adolescent. However, when working from a standpoint of intersectionality, ABFT therapists must integrate discussions of identity and stigma into task II and III work. The success of ABFT with these families depends on the ability of the therapist to address these sociocultural issues. To journey into these themes, therapists must do work on their own self-identity and self-location, immerse themselves in contemporary publications on relational and attachment processes, and employ the therapist self to better understand how culture and context play an essential role in the effectiveness of the therapeutic process.

In terms of contraindications, we perceive in our clinical observations that some family relationships serve as a space of rejection and relational cut off wherein individual therapy may be necessitated for sexual minority youth. Even so, family therapy can be valuable to improve interpersonal relationships overall, increase self-esteem, and encourage identity ownership. In cases of severe trauma, complementary therapies such as trauma-focused cognitive behavior therapy and eye movement desensitization have been found valuable in improving individual coping skills (Balcom, 2000; Carbone, 2008; Martel, Safren & Prince, 2004). Furthermore, under certain

conditions of family violence or within the purview of conversion therapy or cultural considerations wherein non-heterosexuality is illegal, the aid of other resources such as child services to protect the child and couples therapy for the parents might be advisable. If ABFT is found to be unsuitable for any of these reasons noted, referrals can be made to other services.

Many new areas of ABFT research have been initiated: with eating disorders, the college student population, medical family therapy, child welfare agencies, and applying the model in international contexts. This case study of ABFT with a Black, bisexual, cisgender female adolescent illustrates the complex threads of identity and well-being that therapists must intentionally weave together with a client in order to serve their systemic needs. In addition, the case study provides an example of using an intervention-driven evidence-based modality while also considering contextual variables in the client's circle of influence. Future areas of scholarship could include ABFT dissemination and training in wider contexts as well as culture-specific modifications.

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References

- Aponte, H. J., & Kissil, K. (Eds.). (2016). *The person of the therapist training model: Mastering the use of self*. London, UK: Routledge.
- Austin, S., & Harris, G. (2010). Addressing health disparities: The role of an African American health ministry committee. *Social Work in Public Health, 26*, 123–135. doi:10.1080/10911350902987078

- Balcom, D. (2000). Eye movement desensitization and reprocessing in the treatment of traumatized gay men. *Journal of Gay & Lesbian Social Services*, 12(1–2), 75–89. doi:10.1300/J041v12n01_04
- Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology*, 54(3), 306. doi:10.1037/0022-0167.54.3.306
- Bobo, L. D., & Thompson, V. (2006). Unfair by design: The war on drugs, race, and the legitimacy of the criminal justice system. *Social Research: An International Quarterly*, 73(2), 445–472. Retrieved July 11th, 2017, from <http://www.jstor.org/stable/40971832/>
- Boszormenyi-Nagy, I., & Spark, G. M. (1973). *Invisible loyalties: Reciprocity in intergenerational family therapy*. Oxford, UK: Routledge.
- Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York, NY: Basic Books.
- Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among Black lesbians. *Journal of Lesbian Studies*, 7, 87–108. doi:10.1300/J155v07n04_06
- Brown, E. D., Seyler, M. D., Knorr, A. M., Garnett, M. L., & Laurenceau, J. (2016). Daily poverty-related stress and coping: Associations with child learned helplessness. *Family Relations*, 65, 591–602. doi:10.1111/fare.12217
- Callis, A. S. (2013). The black sheep of the pink flock: Labels, stigma, and bisexual identity. *Journal of Bisexuality*, 13(1), 82–105. doi:10.1080/15299716.2013.755730
- Carbone, D. J. (2008). Treatment of gay men for post-traumatic stress disorder resulting from social ostracism and ridicule: Cognitive behavior therapy and eye movement desensitization and reprocessing approaches. *Archives of Sexual Behavior*, 37(2), 305–316. doi:10.1007/s10508-007-9239-3
- Cassidy, J., & Shaver, R. P. (1999). *Handbook of attachment: Theory, research, and clinical applications. Rough guides*. New York, NY: Guilford Press.
- Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989, 139–169.
- 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.
- Diamond, G. M., Shahar, B., Sabo, D., & Tsveli, N. (2016). Attachment-based family therapy and emotion-focused therapy for unresolved anger: The role of productive emotional processing. *Psychotherapy*, 53, 34–44. doi:10.1037/pst0000025
- Diamond, G. M., & Shpigel, M. S. (2014). Attachment-based family therapy for lesbian and gay young adults and their persistently nonaccepting parents. *Professional Psychology: Research and Practice*, 45, 258–268. doi:10.1037/a0035394
- Diamond, G. S. (2005). Attachment-based family therapy for depressed and anxious adolescents. In J. L. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 17–41). Hoboken, NJ: Wiley.
- Diamond, G. S., Diamond, G. M., & Levy, S. A. (2014). *Attachment-based family therapy for depressed adolescents*. Washington, DC: American Psychological Association.
- 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 & Adolescent Psychiatry*, 41, 1190–1196. doi:10.1097/00004583-200210000-00008

- Diamond, G. S., Russon, J., & Levy, S. (2016). Attachment-based family therapy: A review of the empirical support. *Family Process, 55*, 595–610. doi:10.1111/famp.12241
- Diamond, G. S., Siqueland, L., & Diamond, G. M. (2003). Attachment-based family therapy for depressed adolescents: Programmatic treatment development. *Clinical Child and Family Psychology Review, 6*, 107–127. doi:10.1023/A:1023782510786
- Diamond, G. S., Wagner, I., & Levy, S. A. (2016). Attachment-based family therapy in Australia: Introduction to a special issue. *Australian and New Zealand Journal of Family Therapy, 37*, 143–153. doi:10.1002/anzf.1148
- Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-based family therapy for adolescents with suicidal ideation: A randomized controlled trial. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*, 122–131. doi:10.1016/j.jaac.2009.11.002
- Duncan, D. T., & Hatzenbuehler, M. L. (2014). Lesbian, gay, bisexual, and transgender hate crimes and suicidality among a population-based sample of sexual-minority adolescents in Boston. *American Journal of Public Health, 104*, 272–278. doi:10.2105/AJPH.2013.301424
- Feder, M., & Diamond, G. M. (2016). Parent-therapist alliance and parent attachment promoting behaviors in attachment-based family therapy for suicidal and depressed adolescents. *Journal of Family Therapy, 38*, 82–101. doi:10.1111/1467-6427.12078
- Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.
- Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology, 9*, 679–700. doi:10.1177/0003065115602447
- Garber, J., Robinson, N. S., & Valentiner, D. (1997). The relation between parenting and adolescent depression self-worth as a mediator. *Journal of Adolescent Research, 12*, 12–33. doi:10.1177/0743554897121003
- Gottman, J. (2011). *Raising an emotionally intelligent child*. New York, NY: Simon & Schuster.
- Gottman, J. M. (2001). Meta-emotion, children's emotional intelligence, and buffering children from marital conflict. In C. D. Ryff & B. Singer (Eds.), *Emotion, social relationships, and health* (pp. 23–55). New York, NY: Oxford University Press.
- Gottman, J. M., Katz, L. F., & Hooven, C. (1996). Parental meta-emotion philosophy and the emotional life of families: Theoretical models and preliminary data. *Journal of Family Psychology, 10*, 243–268. doi:10.1037/0893-3200.10.3.243
- Gottman, J. M., Katz, L. F., & Hooven, C. (1997). *Meta-emotion: How families communicate emotionally*. Mahwah, NJ: Erlbaum.
- Greenberg, L. S. (2004). Emotion-focused therapy. *Clinical Psychology & Psychotherapy, 11*, 3–16. doi:10.1002/cpp.388
- Greene, B., & Boyd-Franklin, N. (1996). African American lesbian couples: Ethnocultural considerations in psychotherapy. *Women & Therapy, 19*, 49–60. doi:10.1300/J015v19n03_06
- Hancock, A. M. (2007). Intersectionality as a normative and empirical paradigm. *Politics & Gender, 3*(2), 248–254. doi:10.1017/S1743923X07000062
- Hatzenbuehler, M. L. (2011). The social environment and suicide attempts in lesbian, gay, and bisexual youth. *Pediatrics, 127*(5), 896–903.
- Israel, P., & Diamond, G. S. (2013). Feasibility of ABFT for depressed clinic-referred Norwegian adolescents. *Clinical Child Psychology and Psychiatry, 18*(3), 334–350. doi:10.1177/1359104512455811
- Israel, T., & Mohr, J. J. (2004). Attitudes toward bisexual women and men: Current research, future directions. *Journal of Bisexuality, 4*(1–2), 117–134.

- Johnson, S. (2004). *The practice of emotionally focused couple therapy: Creating connection*. New York, NY: Brunner-Routledge.
- King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 8(1), 70. doi:10.1186/1471-244X-8-70
- Kobak, R., Cassidy, J., Lyons-Ruth, K., & Ziv, Y. (2006). Attachment, stress and psychopathology: A developmental pathways model. In D. Cicchetti & D. J. Cohen (Eds.), *Handbook of developmental psychopathology* (pp. 333–369). Cambridge, UK: Cambridge University Press.
- Levy, S. A., Russon, J., & Diamond, G. M. (2016). Attachment-based family therapy for suicidal lesbian, gay, and bisexual adolescents: A case study. *Australian and New Zealand Journal of Family Therapy*, 37(2), 190–206. doi:10.1002/anzf.1151
- Liddle, H. A., Dakof, G. A., Parker, K., Diamond, G. S., Barrett, K., & Tejada, M. (2001). Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *The American Journal of Drug and Alcohol Abuse*, 27, 651–688. doi:10.1081/ADA-100107661
- Lincoln, C. E., & Mamiya, L. H. (1990). *The Black church in the African American experience*. Durham, NC: Duke University Press.
- Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., . . . Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *Journal of Adolescent Health*, 49(2), 115–123. doi:10.1016/j.jadohealth.2011.02.005
- Martell, C. R., Safren, S. A., & Prince, S. E. (2004). *Cognitive-behavioral therapies with lesbian, gay, and bisexual clients*. New York, NY: Guilford Press.
- Mattis, J. S., & Jagers, R. J. (2001). A relational framework for the study of religiosity and spirituality in the lives of African Americans. *Journal of Community Psychology*, 29, 519–539. doi:10.1002/jcop.1034
- McGoldrick, M., & Hardy, K. V. (Eds.). (2008). *Re-visioning family therapy: Race, culture, and gender in clinical practice*. New York, NY: Guilford Press.
- Minuchin, S. (1974). *Families & family therapy*. Cambridge, MA: Harvard University Press.
- Mustanski, B., & Liu, R. T. (2013). A longitudinal study of predictors of suicide attempts among lesbian, gay, bisexual, and transgender youth. *Archives of Sexual Behavior*, 42, 437–448. doi:10.1007/s10508-012-0013-9
- Nguyen, T. Q., Banteen-Roche, K., German, D., Nguyen, N. T., Bass, J. K., & Knowlton, A. R. (2016). Negative treatment by family as a predictor of depressive symptoms, life satisfaction, suicidality, and tobacco/alcohol use in Vietnamese sexual minority women. *LGBT Health*, 3(5), 357–365. doi:10.1089/lgbt.2015.0017
- Nock, M. K., Borges, G., Bromet, E. J., Alonso, J., Angermeyer, M., Beautrais, A., . . . Williams, D. (2008). Cross national prevalence and risk factors for suicidal ideation, plans and attempts. *British Journal of Psychiatry*, 192, 98–105. doi:10.1192/bjp.bp.107.040113
- Pachankis, J. E., Hatzenbuehler, M. L., Rendina, H. J., Safren, S. A., & Parsons, J. T. (2015). LGB-affirmative cognitive-behavioral therapy for young adult gay and bisexual men: A randomized controlled trial of a transdiagnostic minority stress approach. *Journal of Consulting and Clinical Psychology*, 83, Oct 2015, 875–889. doi:10.1037/ccp0000037
- Randazzo, R., Farmer, K., & Lamb, S. (2015). Queer women's perspectives on sexualization of women in media. *Journal of Bisexuality*, 15(1), 99–129. doi:10.1080/15299716.2014.986315
- Restifo, K., & Bögels, S. (2009). Family processes in the development of youth depression: Translating the evidence to treatment. *Clinical Psychology Review*, 29, 294–316. doi:10.1016/j.cpr.2009.02.005

- Ringborg, M. (2016). Dissemination of attachment-based family therapy in Sweden. *Australian and New Zealand Journal of Family Therapy*, 37, 228–239. doi:10.1002/anzf.1153
- Rubinstein, T., Makov, S., & Sarel, A. (2013). Don't bi-negative: Reduction of negative attitudes toward bisexuals by blurring the gender dichotomy. *Journal of Bisexuality*, 13(3), 356–373. doi:10.1080/15299716.2013.813419
- Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*, 123(1), 346–352. doi:10.1111/j.1744-6171.2010.00246.x
- Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing*, 23(4), 205–213. doi:10.1111/j.1744-6171.2010.00246.x
- Santens, T., Levy, S., Diamond, G., Braet, C., Vyvey, M., Heylboeck, E. & Bosmans, G. (2017). Exploring acceptability and feasibility of evidence-based practice in child welfare settings: A pilot study with attachment-based family therapy. *Psychologica Belgica.*, 57(1), 43–58. doi:10.5334/pb.338
- Santens, T., Devacht, I., Dewulf, S., Hermans, G., & Bosmans, G. (2016). Attachment-based family therapy between magritte and poirot: Dissemination dreams, challenges, and solutions in Belgium. *Australian and New Zealand Journal of Family Therapy*, 37, 240–250. doi:10.1002/anzf.1154
- Shearer, A., Herres, J., Kodish, T., Squitieri, H., James, K., Russon, J., . . . Diamond, G. (2016). Differences in mental health symptoms across lesbian, gay, bisexual, and questioning youth in primary care settings. *Journal of Adolescent Health*, 59, 38–43. doi:10.1016/j.jadohealth.2016.02.005
- Siqueland, L., Rynn, M., & Diamond, G. S. (2005). Cognitive behavioral and attachment-based family therapy for anxious adolescents: Phase I and II studies. *Journal of Anxiety Disorders*, 19, 361–381. doi:10.1016/j.janxdis.2004.04.006
- Sroufe, A. (2005). Attachment and development: A prospective, longitudinal study from birth to adulthood. *Attachment & Human Development*, 7, 349–367. doi:10.1080/14616730500365928
- Wagner, I., Diamond, G. S., Levy, S., Russon, J., & Litster, R. (2016). Attachment-based family therapy as an adjunct to family-based treatment for adolescent anorexia nervosa. *Australian & New Zealand Journal of Family Therapy*, 37, 207–227. doi:10.1002/anzf.1152
- Walker, J. J., & Longmire-Avital, B. (2013). The impact of religious faith and internalized homonegativity on resiliency for Black lesbian, gay, and bisexual emerging adults. *Developmental Psychology*, 49, 1723–1731. doi:10.1037/a0031059
- Waters, E., & Cummings, E. M. (2000). A secure base from which to explore close relationships. *Child Development*, 71, 164–172. doi:10.1111/1467-8624.00130
- Watson, M. F. (2013). *Facing the black shadow*. New Jersey, NJ: BookBaby.