**Summary of the Research on Attachment-Based Family Therapy (ABFT)**

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## Outcomes: Empirical support for ABFT

To date, five studies have been carried out to demonstrate the efficacy of ABFT. A sixth study is currently in process. Some of the studies focus on depression as the presenting problem (Diagnosis of MDD), but suicide ideation was present and examined. Other studies focused on suicide ideation or attempts as the presenting disturbance, but usually an elevated level of depression was required for inclusion as well. In this regard, the data to date supports the efficacy of this intervention for reducing depression and suicide ideation and preventing suicide attempts. We also have studies that look at these disorders in specific populations either as independent studies (i.e., GLB suicidal youth) or as secondary analysis of sub groups within a study (i.e., suicidal adolescents with a history of sexual abuse). We also have several studies of the treatment process. This empirical support meets the criteria of a promising intervention (Chambless & Hollon, 1998). In this section, we first provide a description of the treatment studies and then provide a description of the studies of treatment process and treatment adherence measures.

These studies have earned ABFT the distinction as an empirically proven program by the Promising Practices Network (www.promisingpractices.net) and high ratings (3.1- 4.0 out of 4.0) in SAMHSA's National Registry of Evidenced-based Programs and Practices (http://nrepp.samhsa.gov).

**Study I: Family Therapy for Depressed Adolescents (R21MH2920; Diamond et al., 2002).** Further development of ABFT was carried out with the support of an NIMH treatment development grant. The full report of this study is in Diamond et al. (2002). The next generation of the treatment manual and an adherence measure were developed. Then we randomized 32 clinically depressed adolescents to 12 weeks of ABFT or 6 weeks of a wait-list control condition. Patients ranged in age from 13-17 years (mean = 15 years, SD = 1.5). Twenty-five patients (78%) were female and 22 (69%) were African American. Eighty percent came from single parent homes, with 69% having incomes of less than $30,000 a year. When reporting on the six months prior to treatment, 14% reported having a friend or family member killed, 47% reported hearing random gunshots, 31% reported having at least one parent abusing drugs or alcohol, and 19% reported experiencing stressful, unwanted sexual experiences. Analyses comparing the treatment and control groups at baseline revealed no significant differences on any measures including depression (BDI-II, HAM-D, K-SADS), suicidal ideation (SIQ), parental distress (SCL-90), and family functioning. One hundred percent of participants completed post-treatment assessments. In terms of treatment attendance, 19% attended all sessions, 44% attended 9 to 11 sessions, 24% attended 5 to 8 sessions, and 13% attended 3 sessions.

Outcome and Effect Sizes (Diamond et al., 2002; pages 1193-1194). Although the sample was small, many scales showed significant change. Of the 16 treatment cases randomized to ABFT, 13 (81%) no longer met criteria for Major Depressive Disorder (MDD) at post-treatment, while 7 (47%) of the 15 of the waitlisted cases no longer met criteria for MDD post-waitlist ($c_2$ [1] = 4.05, $p < .04$). Though there were not significant differences between the groups on mean BDI score post-treatment, there was a significant treatment condition difference noted in the number of adolescents who had post-treatment BDI scores in the non-clinical level (BDI < 9, $c_2$ [1] = 6.37, $p = .01$;). Sixty-two percent of the adolescents treated with ABFT had a BDI of 9 or less compared to 19% of adolescents in the waitlist condition. The six-month follow-up data on diagnosis was also very promising with 87% of the treated sample not meeting criteria for MDD. Planned

comparisons (group X time) indicated that, compared to the 6-week waitlist, 12 weeks of ABFT was associated with significant reduction in depression (HAM-D), anxiety (STAIC), and family conflict (CON). ABFT also yielded near significant changes in attachment to mother (IPPA-M), hopelessness (BHS), and suicidal ideation (SIQ). Effect sizes for many of the measures are also promising.

**Study II: Family Therapy for Suicidal Youth (R49-CE000428; Diamond et al, 2010).** Recently, we completed a randomized clinical trial funded by the Centers for Disease Control, testing ABFT for adolescents presenting with persistent suicidal ideation (SIQ-JR>31 for several days) that was not serious enough to warrant hospitalization (Diamond et al., 2010). To increase the severity of the sample, eligible adolescents also had to report current elevated depressive symptoms (BDI>20). Sixty-six adolescents were randomized to 14 weeks of ABFT or enhanced usual care (EUC, facilitating referrals to community treatment). The sample included 83% female and 17% male adolescents, ranging in age between 11–18 years (M=15.20, SD=1.61). Of the entire sample, 74% identified themselves as African American, 15% as Caucasian, 3% as Hispanic/Latino, 3% as biracial, and 5% chose „other“ . In addition, 73% came from single-parent families. As an indicator of socioeconomic status, 43% of the participants made less than $30,000, 45% made between $30,000 and $80,000, and 12% made over $80,000. Sixty percent of the adolescents reported having made some kind of suicide attempt in their lifetime, although only 18% reported ever having been hospitalized for emotional or behavioral problems. Independent samples t-test and chi-square analyses revealed no significant differences between the treatment groups on any of these variables.

Outcomes and Effect Sizes. Compared to usual care in the community (M = 16.2, 95% CI, 10.1-22.2), youth treated with ABFT (M = 5.2, 95% confidence interval [CI], 1.6-8.8) demonstrated significantly greater and faster reductions in suicidal ideation during treatment (page 128). These differences persisted at follow-up (ABFT, M = 10.4; 95% CI, 5.6-15.2 vs. EUC, M = 23, 95% CI, 15.6-30.4) with an overall large effect size of .97 (page 125). These findings are strengthened by the consistency across self-report and clinician ratings (page 129). This is one of the few studies to demonstrate that a research treatment was more effective than treatment as usual for reducing suicidal ideation in adolescents (Tarrier, Taylor, & Gooding, 2008). ABFT is even effective with the most severe youth presenting with comorbid anxiety, severe suicide ideation, and history of multiple suicide attempts.

Results also indicated that ABFT was associated with greater rates of clinical recovery (page 127). At baseline, the sample reported average SIQ-JR total scores of 51.1 far exceeding the clinical cut-off score of 31 (Reynolds, 1988). Yet, at the end of treatment, nearly 7 of every 8 participants (87%; 95% CI, 74.6-99.6) receiving ABFT reported SIQ-JR scores, not only below the clinical cut-off of 31, but in a range consistent or below that of a non-clinical sample of similar demographics (Reynolds & Mazza, 1999). For EUC, only slightly more than half (51.7%; 95% CI, 32.4-54.32) achieved this level of recovery. Benefits were maintained at follow-up (ABFT, 70%; 95% CI, 52.6-87.4; EUC 34.6%; 95% CI, 15.6-54.2) with a strong effect size (OR = 4.41).

Depressive symptoms (page 128). ABFT also demonstrated near significant reductions in self-reported depressive symptoms by mid-treatment compared to EUC ($F(1, 64) = 3.00$, $P = 0.09$), and these differences were partially maintained over time ($F(1, 64) = 0.33$, $P = 0.57$). Effect sizes at all time points were very strong (baseline to 6 weeks $d = 0.37$; $t(64) = 1.75$, $P = 0.08$ in favor of ABFT; baseline to follow-up $d = 0.22$; $t(64) = -0.72$, $P = 0.48$ in favor of ABFT), suggesting that a larger sample size may have reached statistical significance. A lack of long-term differences between treatments for adolescent depression is common (Brent, Holder, & Kolko, 1997; Emslie, Rush & Weinberg, 1997), possibly due to the episodic nature of MDD. Still, the data indicate that ABFT provided more rapid relief from depression than community care, a critical consideration for depressed adolescents and their parents. These findings were

supported by the measures of clinical recovery for depression (i.e., BDI-II <9). Compared to EUC, patients in ABFT were four times more likely to report BDI–II total scores in the non-clinical range at mid-treatment (OR = 4.19; 95% CI: 1.03-17.07; $c_2(1) = 4.38$ P = 0.04) and 2.3 times more likely at follow-up (OR = 2.21, 95% CI: 0.76-6.42; $c_2(1) = 2.17$, P = 0.14).

Suicide and Comorbid Diagnosable Depression (page 124). Adolescents suffering from both severe suicidal ideation and diagnosable depression are at considerably high risk for suicide. Among this subsample (n = 35, 53.0%; 16 ABFT), ABFT was superior to EUC (F (1, 33) = 6.16, P = 0.02). Although this subsample is small, effect sizes at 6 weeks actually increased with the severity of the depression (BDI greater than 35= d. 63) for reducing depression. Furthermore, the effect of ABFT for this population appears to be comparable to effects obtained from Cognitive Behavioral Therapy (CBT) and fluoxetine in the context of the TADS study. In the TADS study (TADS, 2004), mean post-treatment SIQ-JR scores were 11.8 for CBT plus fluoxetine, 14.4 for fluoxetine alone, 11.4 for CBT alone, and 15 for placebo. Post-treatment mean SIQ-JR scores for ABFT were 8.0. Although there are sample differences, these comparisons confirm the conclusion of this study: family treatment for suicidal ideation is promising and should be further studied as a primary intervention compared to, rather than as adjunctive to, CBT or medication.

History of Sexual Abuse (Diamond et al., 2012). There is growing interest in effective treatments for depressed and suicidal youth who have a history of abuse (physical or sexual). Several recent depression focused CBT studies (with and without medication) have demonstrated that CBT for depression is not effective when patients have a history of trauma (physical or sexual; Arsanow et al., 2009; Barbe et al., 2004; Lewis et al., 2010; Shirk et al., 2009). In contrast, suicidal patients treated with ABFT did as well as patients without trauma and better than patients treated in the control condition as rated by the Suicide Ideation Questionnaire and Suicide Severity Index (Diamond et al., 2012). Among adolescents with a history of sexual abuse (HST), those who received ABFT had significantly lower suicidal ideation (mean=7.94, SD=12.09) than those who received EUC (mean=13.73, SD=10.15, p=.05). Further, for adolescents with a HST, rates of change were higher in ABFT than EUC on self-reported suicide ideation (SIQ-JR) from baseline to post-treatment (with a strong effect size d=.73), and benefits were maintained from post-treatment to follow-up. As important, there was no significant difference on outcome between the sexually abused and non abused patients treated in ABFT).

Retention. The retention data are particularly important. ABFT retained adolescents in treatment (number of sessions, M = 9.71, SD = 5.26) longer than community treatment (M = 2.87, SD = 3.3; Z = -4.74, P < .001) even with the additional supports offered in our EUC model (Diamond et al., 2010, page 129). This length of stay in outpatient treatment is impressive for any adolescent focused treatment, let alone treatment with suicidal, low income urban youth (Spirito & Esposito-Smythers, 2006). The retention was also better than several research studies that have designed treatments specifically to enhance engagement and retention (Rotheram-Borus et al., 1996; Spirito et al., 2002). This is one the few studies targeting suicidal adolescents to demonstrate that an intervention was more effective than treatment as usual.

**Study III: Family-Based Treatment of Depressed Adolescents: An Empirical Study With Norwegian Adolescents in Specialty Mental Health Care (NCT00700609; Israel & Diamond, 2012).** Three therapists were trained and credentialed to provide ABFT. Twenty adolescents meeting criteria for MDD in three outpatient community clinics in southwest Norway were randomized to ABFT or treatment as usual (TAU). The sample was majority female (55%), ranging between the ages of 13 to 17 (M = 15.6, SD = .99). Results (page 10) showed that patients treated with ABFT had significantly lower ratings on the Hamilton Depression Inventory (HAM-D) ( z = -2.05, p = 0.04), and higher rates of recovery (BDI >12) than patients treated in usual care (z = -.49, p = .23). Adolescents in ABFT had significantly better symptom reduction than adolescents in TAU on clinician ratings (ES = d = 0.8; page 9). This pilot project was the first

effectiveness study for ABFT showing that we could train community providers and improve outcomes over community care.

**Study IV: Attachment Based Family Therapy for Suicidal Gay, Lesbian, and Bisexual youth (AFSP); Diamond et al., 2011).** ABFT was adapted to meet the unique needs of suicidal, openly LGB youth and their parents. Additionally, pilot data on the feasibility and efficacy of the treatment was gathered. In Phase I, a treatment development team modified ABFT to meet the unique needs of LGB suicidal youth. In Phase II, 10 suicidal LGB youth were offered 12 weeks of LGB sensitive ABFT. Adolescents' report of suicidal ideation, depressive symptoms, and maternal attachment–related anxiety and avoidance were gathered at pretreatment, 6 weeks, and 12 weeks (posttreatment). In Phase I, the treatment was adapted to: (a) include more individual time working with parents in order to process their disappointments, pain, anger, and fears related to their adolescent's minority sexual orientation; (b) address the meaning, implications, and process of acceptance; and (c) heighten parents' awareness of subtle yet potent invalidating responses to their adolescents' sexual orientation. In Phase II seven of the 10 families completed a full course of treatment. Results of Phase II suggest this population can be recruited and successfully treated with a family based therapy, evidenced by high levels of treatment retention and significant decreases in suicidal ideation, depressive symptoms, and maternal attachment–related anxiety and avoidance. This is the first family-based treatment adapted and tested specifically for suicidal LGB adolescents. Though promising, the results are preliminary and more research on larger samples is warranted.

**Study V: Family Therapy for Hospital Aftercare for Adolescent Suicide Attempters (Diamond, Levy, & Creed, under review).** In 2011, we completed a pilot study testing the feasibility, acceptability and outcomes of Attachment-Based Family Therapy (ABFT; Diamond et. al, 2002) as an aftercare model. We aimed to build on the gains made during inpatient treatment and reduce risk factors for future suicide attempt. Additionally, we sought to strengthen our partnership with an adolescent inpatient unit, creating an infrastructure for long-term collaboration in suicide research. Twenty adolescents (80% female, 65% identified as African American), with mean age of 14.9 years, and a parent/caregiver were recruited from inpatient care following a suicide attempt. Of the parents, 8 (40%) had an income under $30,000, 14 (70%) were single or separated/divorced, and 7 (35%) had no more than a high school education. Families were randomized to 16 weeks of either ABFT or Enhanced Usual Care (EUC). As a result of variety of means to build a relationship with a local psychiatric hospital (meeting with hospital staff, holding case conferences, quick response time to referrals [intake within 48 hours of discharge], follow-up post referral, and hosting free educational presentations) we were able to successfully join with the hospital and create a lasting research infrastructure to support future research projects. ABFT was a welcomed option by all of the social workers, nurses, and psychiatrists on the inpatient unit. In terms of feasibility, we met our recruitment goals, the majority of families were interested in receiving family therapy (74% of those referred) and those that got ABFT attended sessions regularly (mean = 11.2 sessions). Additionally, we were able to collect weekly data from participants the majority of the time and collect post treatment data from 90% of the participants. Participants receiving ABFT indicated they were marginally statistically significantly more satisfied with treatment than those receiving EUC ($t(12)=2.02$, $p=0.07$). Related to effectiveness, results show that compared to EUC, ABFT was more marginally significantly more effective at preventing future suicide attempts (0% ABFT, 16.7% EUC $Chi(1)=3.60$, $p=0.058$; Fisher's exact $p=0.206$), reducing attachment related avoidance for mothers ($F(1,9)=3.85$, $p=0.08$), and ABFT participants received treatment faster than EUC participants ($t(6)=-2.09$, $p=.08$). Additionally, ABFT compared to EUC was statistically more effective at reducing attachment related anxiety for fathers ($F(1,3)=12.33$, $p=0.04$). Overall, the results of this study demonstrate that ABFT is both a feasible and acceptable treatment as aftercare for youth with a suicide attempt after discharge from inpatient care.

**Studies in progress.**

**Study VI: Attachment Based for Family Therapy for Suicidal Adolescents (Application Number RO1 MH091059-01)** This study essentially replicates Study III above with a larger sample and a stronger control group. This study aims to test the efficacy of ABFT using a comparison group that controls for treatment dose, duration, therapist expertise, ecological factors, and family involvement. The study includes one year follow-up data, assessment staff blind to treatment condition, and tests of the purported active ingredients of ABFT. Putative change processes will be tested including: a) adolescents' expectancies for parent availability, b) emotion regulation during parent-adolescent conflict discussions, and c) resolution of loss and abuse. To test this, Dr. Kobak, a leading adolescent attachment researcher, will use the Adult Attachment Interview and observational coding of the family interaction task to test these treatment mechanisms. If successful, the findings will provide evidence for both the efficacy and specificity of a family based treatment mechanism.

We are recruiting and randomizing 130 adolescents to 16 weeks of ABFT or Family Enhanced-Non-directive Supportive Therapy (FE-NST). Assessments are conducted at baseline, 8, 16, 32, and 52 weeks. The primary and secondary aims assess whether ABFT reduces suicidal ideation, depression, family conflict, and future suicide attempts more effectively than the control condition. Exploratory aims test a) whether ABFT can improve parent-adolescent attachment, b) if attachment mediates outcome, and c) if a history of trauma, parental depression or family conflict moderate outcome. The study targets adolescents with severe and persistent suicidal ideation selected from inner city, minority youth.

**Process Research Studies.**

Treatment outcome studies tell us important information about the efficacy of a given treatment with a given audience. However, this methodology tells us little about the why a treatment might work and the effectiveness of the proposed treatment mechanisms. Process research looks inside the "black box" of therapy and tries to identify, describe, test and amplify the proposed active ingredients of clinical changes within a give model. These studies tend to use small population samples, are usually labor intensive, and are often more discovery oriented rather than hypothesis testing. We have conducted several process research studies looking at the mechanism of change in ABFT.

Attributional shifts during the relational reframe (Diamond et al., 2003, pages 119-120). Our first process study focused on the relational reframing task since it sets the foundation for the rest of the treatment. We sought to understand what processes were involved in shifting the treatment focus from "adolescent as the problem" to "strengthening family relations as the solution." We developed a parent and adolescent, pre- and post-session self-report questionnaire to assess changes in clients' views of responsibility for causing and correcting the problems that brought them to treatment. The questionnaire was given to consecutive families at the first treatment session at a community mental health clinic. The depressed adolescents rated both themselves and their parents, and conflicts with parents as high in contributing to the problem. In addition, they rated themselves and parents as very responsible and willing to help solve the problem. Interestingly, parents rated themselves as low in contributing to the problem pre treatment, but capable and willing to help solve the problem. This data highlighted that the adolescent would welcome an interpersonal treatment focus. Parents, although willing to help, were less sure about their contribution to the problem and solution, and therefore, would need guidance in approaching the treatment from this perspective.

Because the families generally rated themselves high pre-treatment on having an interpersonal construction of the problem, the measure was not sensitive to post-session change. Therefore, eight parents were interviewed after the first session using a videotape recall method (Elliot, 1984). Among other things, parents approved of the initial siding with adolescents, but expected more equanimity in later sessions. However, parents did like the treatment focus. The interviews more clearly elucidated the role that emotions played in the relational reframe process. Eliciting strong, often vulnerable emotions associated with these

conflicts helped to challenge negative and often ridged cognitions about problems and about the adolescents themselves (Greenberg & Safran, 1987). In particular, the greatest clinical leverage occurred when parents came to understand how ruptures in the parent-adolescent relationship contributed to the depression. Understanding the adolescents‟ desire to be loved helps resuscitate an emotional connection that motivates parental commitment rather than abandonment.

Alliance Building with the Adolescents and Parent (Diamond et al., 2003; page 121). The authors sought to understand both the contribution of general therapeutic alliance and specific ABFT alliance processes to outcome. Twenty-three individual sessions with adolescents and 23 individual sessions with parents in the ABFT outcome study were assessed using a modification of the VTAS (Hartley & Strupp, 1983) and a new measure with ABFT specific items. For the adolescents, none of the ratings of VTAS were significantly correlated with depression outcomes, but there was a trend toward association between alliance and a decrease in parent-adolescent conflict. For the ABFT specific items, there was a trend for adolescent agreement on individual goals to be associates with change in self-reported depression. Adolescent agreement on family goals was not associated with change.

For the parent, overall parent alliance was significantly related to both parents‟ rating of improvement in adolescent depression, as well as agreement on individual and family goals for treatment. Having a positive view of therapy (or more specifically not having a negative view of therapy) was related to mother's ability to articulate and agree on individual goals for herself in therapy. We also found that when the therapist initiated the goal of improving family functioning, adolescents reported improvement in both cohesion and perceived attachment to parents. This finding suggests that if the therapist retains his or her focus and the therapeutic freamework is meaningful, relevant, and accurate, he or she can succeed in improving family relationships, regardless of whether the adolescent initially agrees to these goals.

The Alliance Building Process with Parents (Diamond et al., 2003; pages 121-122). To better understand the actual therapeutic processes that lead to good alliances with parents, we conducted a Task Analytic study (Rice & Greenberg, 1984) of the therapist-parent alliance task (Diamond, Moed, Diamond, & Shelef, 2002). First, a rational or theoretical model was developed based on clinical experience and theory. Second, videotapes of three good and two bad parent alliance sessions were chosen for intensive observation and coding. Observational rating systems included the ABFT adherence measure to characterize therapist interventions, the Cognitive Constructions Coding System (Friedlander & Heatherington, 1998) to capture client's shifts in problem constructions and the Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969; Klein, Mathieu-Coughlan, & Kiesler, 1986) to assess client's level of engagement in the treatment episode. This analysis yielded a five stage clinical model: 1) Bond and Acknowledgement, 2) Bond and Empathy, 3) Relational Reframe, 4) Setting Goals and Tasks, 5) Bond and Acknowledgement.
In general, the pattern of therapist behavior during successful alliance sessions progressed from support and empathy to confrontation and working through and then back to support and empathy. In contrast, the two poor alliance cases demonstrated different characteristics from both each other and from the good alliance cases. In the first poor alliance case, there was a gradual and significant decrease in the therapist's use of alliance building interventions over the course of the session and no increase in the use of relational reframe or vulnerable emotions statements in Stages 3 and 4. The therapist appeared to "give up" in the face of a much disengaged grandmother. The second poor alliance session was dominated by high levels of interventions focused on alliance building and relational reframing. For the client there was no shift toward interpersonal problem construction as in the successful cases even though the therapist persisted in making relational reframing interventions. In addition to providing a detailed clinical map of alliance building procedures, these findings suggest that, as with treatment outcome, alliance may be a necessary foundation for the success of specific, goal-oriented, within-session interventions as well.

The Relational Reframe and Parents' Problem Constructions in Attachment-based Family Therapy (Moran, Diamond, & Diamond, 2005). The authors studied the impact of relational reframes on parents' problem constructions and the reciprocal impact of parents' problem constructions on therapists' use of the relational reframe in five early sessions of attachment-based family therapy for depressed adolescents. Across all five sessions, relational reframes led parents to construct problems in interpersonal terms in at least two of their six subsequent speech turns (page 229). There was partial support for the hypothesis that reframes led to shifts in parents' constructions, from intrapersonal to interpersonal (page 231). In good, but not poor alliance sessions, parents' interpersonal problem constructions led therapists to use relational reframes (page230). Future research should examine not only how interpersonal problem constructions are generated, but their quality as well.

Generating nonnegative attitudes among parents of depressed adolescents: The power of empathy, concern, and positive regard (Moran & Diamond, 2008). Parental negativity is associated with the onset and maintenance of adolescent depression. Reducing parental negativity is a primary focus of family-based treatments for this clinical population. This study examined the association between therapist relationship-facilitating and attachment-oriented interventions and the valence (i.e., positivity-negativity) of parents' attitudes toward their depressed adolescent in a sample of 13 sessions of ABFT. Lag sequential analyses revealed that in good alliance sessions relationship-facilitating interventions, such as empathy and positive regard for the parent, were associated with parents' nonnegative attitudes toward their adolescent in the five speech turns subsequent to the intervention (page 103). Attachment-oriented interventions, such as relational reframes, addressing core relational themes, and highlighting vulnerable emotions, were also intermittently associated with nonnegative parental attitudes in good alliance sessions (page 104). No such effects were evident for the comparison interventions (page 104). This study represents a first step in the process of testing specific strategies for reducing parental negativity in family therapy.

ABFT: Adherence and Differentiation (Diamond, Diamond, & Hogue, 2007). This study examined the fidelity of attachment-based family therapy (ABFT) for depressed adolescents. Trained observers used the therapist behavior rating scale (3rd version) to code therapist behaviors in 45 sessions of ABFT and 45 sessions each from two empirically based treatments for adolescent substance abusers: multidimensional family therapy (MDFT) and cognitive-behavioral therapy (CBT). Results indicated that ABFT therapists employed essential ABFT interventions, such as focusing on vulnerable affect, highlighting attachment-related themes, and promoting adolescent-parent reattachment through in-session enactments (page 185). In accordance with the sequential nature of the treatment, these interventions were used more extensively during the early stage of treatment, when there is a greater focus on reattachment. ABFT was perfectly discriminable from CBT, with ABFT therapists using more restructuring and reattachment interventions and CBT therapists using more signature CBT interventions, such as cognitive monitoring and homework (page 185). ABFT was also discriminable from MDFT, with ABFT therapists placing a greater emphasis on reattachment (page 185). These results suggest that ABFT is a viable and differentiated treatment. Together with prior findings supporting its efficacy, ABFT should be considered a promising new approach for working with depressed adolescents and their families.

Repairing Attachment in Families with Depressed Adolescents: A Task Analysis (Stern & Diamond, under review). This exploratory, hypothesis generating pilot study (N=3) used Task Analysis (Rice & Greenberg, 1984) to refine a model of the parent-adolescent Attachment Task in ABFT. The Attachment Task aims to repair long-standing parent-adolescent relational conflicts that may be associated with adolescent depression. As a supplement to the development of an ideal clinical model of the task (Diamond & Stern, 2003), videotapes of two successful and one unsuccessful Attachment Task episodes were coded with the Structural Analysis of Social Behavior (SASB; Benjamin, 1974). SASB analysis helped

refine and embellish our evolving model of the task, suggesting that the Attachment Task success was associated with high parent affiliation and autonomy (page 12). There was also partial support for a phase model of the task, in which successful sessions were associated with a parent disclosure phase that showed both independence and warmth.

Changes in Parenting Paper (Shpigel, Diamond & Diamond, under review). This paper investigates whether ABFT led to decreases in parental psychological control and increases in parental psychological autonomy granting and whether such changes were associated with changes in adolescents' attachment schema and psychological symptoms. Eighteen suicidal adolescents and their mothers were treated using ABFT. Adolescents reported on their representations of parents and levels of depressive and suicidal ideation at pretreatment, mid-treatment, post-treatment, and 3 months post-treatment. Parents' psychological control and autonomy granting behaviors were observed and coded at session 1 and session 4. Over the first  weeks of therapy, parental psychological control decreased and parental autonomy granting increased (page 12). Moreover, increases in parental autonomy granting were associated with increases in adolescents' perceptions of parental careand decreases in attachment related anxiety and avoidance (page13). Finally, decreases in adolescents' perceived parental control during the treatment were associated with reductions in adolescents' depressive symptoms from pre-treatment to three months post-treatment (page14). ABFT appears to improve parental behaviors among parents of suicidal adolescents. Increases in parental autonomy granting seem to be linked to reductions of attachment related anxiety and avoidance and increased the adolescents' perceptions of parental care which, in turn, seems to impact adolescents' affective state. This is the first study empirically examining putative change mechanisms in ABFT.

ABFT v. Emotional Focus Therapy for Reducing Unresolved Anger (in progress, ISF 1079/09). Clients frequently present for therapy with lingering, unresolved anger toward a parent. Such anger may best be understood as a secondary, defensive response to underlying, primary emotions such as hurt and sadness. A number of individual and conjoint emotion focused, experiential therapies have been developed and shown to be efficacious for treating unresolved anger.  In individual, process experiential therapy, empty chair dialogues or *imaginal enactments* are used to help clients access and express suppressed or avoided unmet attachment needs and associated vulnerable feelings (e.g., hurt, sadness, longing) to their parent *as if the parent were sitting in the room across from them.*  During these imaginal interactions, clients also imagine and act out their parent's response. ABFT, on the other hand, utilizes *conjoint, in vivo enactments* between clients and their parents during which clients accesses and express previously suppressed or avoided unmet attachment needs and associated vulnerable emotions (e.g., hurt, sadness, longing) directly to their parents who are actually *present in the therapy room*. Simultaneously, parents are prepared and helped to respond in a non-defensive, empathic  caring manner.  The purpose of this study is to examine whether in vivo enactment is more efficacious than imaginal enactment in resolving lingering anger, and whether anger resolution is mediated by the degree to which vulnerable, primary attachment related emotions (i.e., hurt, sadness) are aroused and by shifts (i.e., more benevolent) in representations of parents.  Forty adults reporting unresolved anger toward a parent are being randomly assigned to either 10 sessions of individual process-experiential therapy, including an empty chair imaginal enactment delivered in the fourth session or 10 sessions ofABFT, including a conjoint, in vivo enactment, also delivered in the fourth session. Degree of unresolved anger and quality of parental representations will be measured pre-treatment, pre-enactment, post-enactment, 1-week post enactment, and post-treatment. Level of emotional arousal during the enactment will be measured via observational and objective physiological measures (i.e., finger temperature and vocal acoustical parameters). Quality of parent response during enactment (real or imagined and acted out) will be coded observationally. We hypothesize that: 1) In vivo enactments will lead to greater pre- to post-enactment; pre- to one-week post-enactment; and pre- to post-treatment decreases in unresolved anger and increases in anger resolution than imaginal enactments; 2) The association between group (in vivo vs. imaginal) and anger resolution will be mediated by both shifts in parental representations (e.g., more

benevolent, caring) and degree of arousal of primary, vulnerable attachment related emotion (e.g., sadness) and; 3) All of the effects above will be moderated by the quality of parental response (whether real, as in the case of in vivo enactments, or acted out, as in the case of imaginal enactments). This is the first study to examine the relative utility of conducting in vivo enactments – the sine qua non of family and couple therapy. It is also among the first to use physiological and voice acoustical measures to objectively assess and examine the role of emotional arousal in psychotherapy.

**Fidelity Measures**

Monitoring the fidelity of an intervention in a clinical trial and in dissemination of an EST treatment is an essential function. The most common method for this is the use of adherence and or competency rating scales. These scales operationalize the manual；s prescribed intervention strategies or techniques. In clinical trials, objective coders are trained to rate therapy tapes to ensure the treatment is being delivered with fidelity. In training and dissemination studies, this tool is used to ensure therapists adequately learn the model and can deliver it as intended (fidelity). We have developed and validated an adherence measure and are developing a second generation version of this tool to help facilitate training and dissemination.

*Our first Adherence Rating Scale.*

ABFT adherence measure. The Therapist Behavior Rating Scale-3 (TBRS-3; Diamond, Hogue, Diamond & Siqueland, 1996) was designed to capture prescribed and emphasized ABFT therapist behaviors, including 5 essential ABFT interventions (relational reframes, focus on vulnerable emotions, planning reattachment episodes, conducting reattachment episodes, focus on core relational themes), 5 more general family therapy skills (e.g., enactment, discussing parental monitoring), and 4 alliance building skills (e.g., expressing empathy). For differentiation purposes, we included 4 CBT interventions (e.g., homework, challenging distorted cognitions).

In a validation study comparing ABFT, Multidimensional Family Therapy (MDFT) and CBT for substance abusing and depressed adolescents (Diamond, Diamond, & Hogue, 2007), the TBRS-3 items demonstrated reliability with ICCs ranging from good (.69) to excellent (.96; page 183). Therapist scores on the 5 intervention clusters (reattachment, restructuring, CBT, adolescent alliance, parent alliance) could perfectly discriminate ABFT from CBT, and could distinguish between ABFT and MDFT on reattachment (Diamond, Diamond, & Hogue, 2007; page 183). Most importantly, ABFT therapists used prescribed ABFT interventions at moderate to high levels. These findings suggest that ABFT is a viable and differentiated treatment approach.

Implementation procedures for clinical training. There is a therapist and supervisor version of the TBRS-3. Therapists use this tool to rate each session as a means of self-monitoring or assessing their behavior in the treatment room: How thoroughly did they do the ABFT interventions strategies? The supervisor version is used when a supervisor watches a live or recorded therapy session. Therapists and supervisors discuss their common and divergent perspectives on the case during individual phone consultation.

*Second Generation Adherence Rating scale*.

During our last trial, we found the need to have therapist rate each session. Ratings focus on which task they delivered, how well it went, what the outcome was and what the barriers where. We found this to be a helpful tool in the supervision sessions, allowing the supervisor to focuses more clearly on a specific treatment task and allowed the therapist to think about where they are at any given stage of the treatment.

*Third Generation Adherence Rating scale.*

As we have begun to do more training and credentialing, we found the need for an even more specific rating

of each task. Certification depends on the ability of a therapist to deliver specific elements of the task in a competent and sensitive manner. The model for this emerges from Task Analysis (Greenberg et al, 1986), a process research methodology for looking at specific "events" in therapy. This approach is the back bone of ABFT in that the five treatment tasks are viewed as discreet, but interactive treatment tasks or events that make up the active ingredients of the therapy. The task analysis methodology leads investigators to define, in micro sequences, the ideal progression or model of how a session should go for a specific task. After studying many successful and unsuccessful versions of a specific task (e.g. video tapes), one arrives at the ideal treatment sessions if things went as well as could be imagined including resolving barriers if necessary. This model provides an ideal map that can guide the therapist through the desired elements and anticipated barriers and challenges of a given task. The ideal model is not meant to be restrictive, but to provide some foundation upon which to judge how well a given task is going and to keep the therapist focused even with the full range of idiosyncratic material presented by each family.

Therefore, we have developed yet another generation of fidelity measures. There are five measures corresponding to each task. Each measure reflects the essential elements of that task. Therapists get a higher rating as they either include more of those elements (cumulative judgment). The highest scores contain elements of competency, rating the therapist's ability to administer the model responsively and respectfully or with more emotional focus. The ratings scales are very detailed and specific and thus far are a very welcomed tool in the training experience. Therapists feel like they actually have a specific and detailed description of what they are trying to learn.