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Attachment-Based Family Therapy for Depressed Adolescents: Programmatic Treatment Development

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Few effective psychosocial treatment models for depressed adolescents have been developed, let alone ones that use the developmentally potent context of the family as the focus of intervention. Attachment-based family therapy (ABFT) is a brief, manualized treatment model tailored to the specific needs of depressed adolescents and their families. Attachment theory serves as the main theoretical framework to guide the process of repairing relational ruptures and rebuilding trustworthy relationships. Empirically supported risk factors for depression are the primary problem states that therapists target with specific treatment strategies or tasks. Parent problem states include criticism/hostility, personal distress, parenting skills, and disengagement. Adolescent problem states include motivation, negative self-concept, poor affect regulation, and disengagement. Intervention tasks include relational reframing, building alliances with the adolescent and with the parent, addressing attachment failures, and building competency. A small, randomized clinical trial provides initial support for the model. Several process research studies, using both qualitative and quantitative methods, have helped refine the clinical guidelines for each treatment task. ABFT is a promising new treatment for depressed adolescents and more research on it is warranted.

KEY WORDS: adolescence; depression; family therapy; attachment; treatment manual.

INTRODUCTION

The Problem and the Need

Recent epidemiological evidence suggests that the prevalence of depressive disorders in the general adolescent population is between 4 and 8%, with 20% of adolescents experiencing a diagnosable depressive episode by age 18 (Birmaher, Ryan, Williamson, Brent, et al., 1996; Lewinsohn, Hops, Roberts, Seeley et al., 1993). These estimates are even higher in psychiatric populations (61%) where depression and affective disorders make up approximately 33% of admissions to psychiatric hospitals for youth 10–17 years old (U.S. Congress, Office of Technology Assistance, 1991). The consequences of childhood depression can be devastating. These include a decrease in school performance, withdrawal from social relations, increase in family conflict, and an increased risk of suicide (Brent et al., 1988; Puig-Antich et al., 1985; Stark, 1990). In addition, depression often occurs in conjunction with other psychiatric disorders, particularly conduct and anxiety disorders, further complicating the development of these youths (Cicchetti & Toth, 1998). Although many patients recover from a Major Depressive Disorder (MDD), they remain at high risk for recurrent episodes and are more likely to suffer from depression as adults (Birmaher et al., 1996; Harrington, Fudge, Rutter, Pickles, & Hill, 1990). In short, depression can have a harmful effect on the developmental trajectory of children and adolescents.

Unfortunately, the development and evaluation of treatments for depressed children and adolescents

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has been limited. Few adequately designed studies are available to establish the safety and efficacy of any class of medication for childhood and adolescent depression (Emslie, Walkup, Pliszka, & Ernst, 1999). Only three well-designed studies of Selective Seritonium Re-uptake Inhibitor (SSRI) for adolescent depression have demonstrated positive results (Emslie, Heiligenstein, et al., 2002; Emslie, Rush, et al., 1997; Keller, Ryan, Strober, et al., 2001). Consequently, guidelines from the American Academy of Child and Adolescent Psychiatry recommend psychotherapy as the first line of intervention (Birmaher et al., 1996).

Limited research on psychosocial treatment exists as well. In the most recent comprehensive review of psychosocial treatment (Kaslow & Thompson, 1998), eight treatment and prevention studies with depressed adolescents were identified. Since then, three new studies have been completed (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Mufson, Weissman, Moreau, & Garfinkel, 1999; Rosselló & Bernal, 1999). Six of these studies used some form of Cognitive–Behavioral Therapy (CBT; Brent et al., 1997; Clarke et al., 1995; Lewinsohn, Clark, Hops, & Andrews, 1990; Lewinsohn, Clark, Rhode, Hops, & Seeley, 1996; Reynolds & Coats, 1986; Rosselló & Bernal, 1999). Three studies focused on Interpersonal Therapy (Mufson et al., 1994, 1999; Rosselló & Bernal, 1999). All studies demonstrated positive outcome for the active treatments at post and 6 months to 2-year follow-up assessments, but relatively few differences between treatments.

Only three of the studies focused on parents or families. Both studies by Lewinsohn and colleagues included parents in a separate brief CBT skills training group. Surprisingly, the addition of that component did not add significantly to the outcome. Brent et al. (1997) tested a family therapy (FT) model against individual CBT (developed by Brent) and supportive psychotherapy. Although CBT produced results more rapidly than the other treatments, 60–70% of study patients showed similar magnitudes of improvement on the Hamilton Depression Scale (Hamilton, 1960) and rates of remission of MDD. In addition, CBT and FT patients showed similar reductions in suicidal ideation.

The lack of development and testing of family-based treatments for depressed youth is striking in view of the call for more developmentally sensitive treatments that address the unique features of depression during childhood and adolescence (Hammen, Rudolph, Weisz, Rao, & Burge, 1999). Furthermore, increasing evidence suggests that family discord plays a critical role in the development, maintenance, and relapse of child and adolescent depression (Asarnow, Goldstein, Tompson, & Guthrie, 1993; Birmaher et al., 2000; Burbach & Borduin, 1986; Emslie et al., 1999; Goodyer, Herbert, Tamplin, Secher, et al., 1997; Keitner, Miller, Epstein, Bishop, & Fruzzeti, 1987). Consequently, investigators have encouraged the development and testing of family treatments for this population (Kazdin, 1991; Kutcher, Boulos, Ward, Marton, et al., 1994; Rutter, 1988). Toward this goal, Attachment-Based Family Therapy (ABFT) has been developed.

ABFT is a developmentally based, semistructured, yet interpersonally focused, brief intervention tailored to the specific needs and characteristics of depressed adolescents. The model relies on interpersonal models of depression (Joiner & Coyne, 1999), particularly Attachment Theory (Bowlby, 1969) and Contextual Family Therapy (Boszormenyi-Nagy & Sparks, 1984) as its theoretical foundation. The clinical procedures draw heavily from Structural (Minuchin, 1974) and Multidimensional Family Therapy (Liddle, 1999) as well as emotionally focused therapy (Greenberg & Johnson, 1988). This paper provides an overview of the programmatic development of this approach. We describe the model's theoretical foundations, empirically defined risk factors, proposed mechanisms of change, and core treatment tasks. Preliminary efficacy and adherence data are presented. Finally, we review several process research studies that have helped develop and refine the treatment approach.

Theoretical Foundations of ABFT

The Interpersonal Context of Depression

Biology, cognitions, social skills, parental psychopathology, and environmental stressors may all contribute to the onset and maintenance of childhood depression (Gotlib & Hammen, 1992). Although ABFT does not ignore this complexity, it focuses primarily on the interpersonal risk factors and processes associated with depression. Many interpersonal theories of depression have emerged in recent years that focus on sociophysiology (Gardner & Price, 1999), feminist theory (Jack, 1999), family interaction (Coyne, 1976), and transactional models (Lynch & Cicchetti, 1991) to name a few. These theories are supported by a growing body of empirical research suggesting that depression can be caused, maintained, or

exacerbated by interpersonal relationships (Sheeber, Hops, & Davis, 2001). For example, parental depression, marital conflict, ineffective parenting practices, unmet attachment needs, loss, and negative parent–child interaction have repeatedly been associated with the etiology and reinforcement of depression (Asarnow et al., 1993; Harris, Brown, & Bifulco, 1986; Cummings & Davies, 1994; Greenberg, Siegel, & Leitch, 1983; Weissman & Paykel, 1974). Even the cognitive aspects of depression (e.g., negative self-schema, learned helplessness) may have their origins in interpersonal (i.e., family) relationships (Beck, Rush, Shaw, & Emery, 1979).

One interpersonal view on depression proposes that adolescent depression may be associated with an adolescent's failure to negotiate autonomy from parents while maintaining closeness and intimacy (Allen & Land, 1999; Powers & Welsh, 1999). This view is founded on the empirically supported contemporary view that healthy individuation depends on relational continuity in the parent–child relationship (Grotovant & Cooper, 1993; Steinberg, 1990). To accomplish this, families must tolerate moderate levels of conflict while the adolescent increases assertions of autonomy (Baumrind, 1987; Holmbeck, 1996: Smetana & Dillard, 1992). Neither extreme conflict, nor the lack of conflict, facilitates this developmental task. Unfortunately, depressed adolescents and perhaps girls in particular, tend to be irritable (leading to harsh conflict) yet overly dependent. Adolescents with this "agitated submissiveness" (Powers & Welsh, 1999) who live in a family with low conflict tolerance (i.e., avoid negotiation of differences) are at higher risk for developing and maintaining depression (Allen & Land, 1999).

Attachment Theory

Attachment theory provides both a theoretical understanding of the attachment/autonomy task and provides direction for clinical intervention. Attachment theory rests on the assumption that humans innately strive for connection with others (Bowlby, 1969, 1988). When a parent appropriately responds to this need, children generally develop a secure attachment style. Although attachment research has mostly focused on infants and young children, the importance of appropriate attachment during adolescence has been well documented (e.g., Grotevant & Cooper, 1993; Steinberg, 1990). Although secure attachment supports healthy development, insecure attachment has repeatedly been associated with depression in adolescents (Ainsworth, 1989; Cole-Detke & Kobak, 1996; Greenberg et al., 1983; Kobak & Sceery, 1988; Rosenstein & Horowitz, 1996).

Having a secure attachment during adolescence depends on three factors. The adolescent must have open communication with the primary caregivers, these caregivers are accessible, and they will provide protection and help if needed (Ainsworth, 1989; Kobak, Sudler, & Gamble, 1991). When these conditions are met, adolescents maintain a felt sense of security and report greater autonomy seeking behavior, positive peer relations, and higher self-esteem (Allen & Land, 1999). Within this relational context, adolescents freely express negative emotions (e.g., fear, anger, distress) with the expectation of acceptance and comfort, rather than the fear of criticism and abandonment. Secure attachment leads to more direct communication, which fosters perspective taking and problem-solving skills (Koback & Duemmler, 1994) the essential skills needed to negotiate autonomy and individuation (Allen & Land, 1999).

In contrast, a caretaker's unavailability and unresponsiveness, particularly at critical moments, leads to insecure attachment. Rather than providing safety and support, caretakers become a source of potential emotional injury. Insecurely attached adolescents perceive the expression of negative feelings as unwelcome and unsafe, which reinforces the negative schema of self and others, and thus makes them vulnerable to depression (Cicchetti, Toth, & Lynch, 1995; Kobak et al., 1991). Lacking confidence in the stability of interpersonal relationships, depressed adolescents avoid assertions of autonomy for fear of reprisal. While behavioral autonomy may be permitted (e.g. staying out late) psychological autonomy is suppressed (Barber, 2002). In a population where loss, neglect, and abuse are common experiences (Alexander, 1993; Cicchetti & Toth, 1998), depressed adolescents lack the skills and the safe context to work through or make appropriate claims of reparation for these interpersonal injustices. Consequently, these children internalize a model of self as unworthy of love, and of other as untrustworthy (Bartholomew & Horowitz, 1991). Therefore, rather than appropriately seeking redress for interpersonal injustices, they act out destructively towards self or others. Clinical experience suggests that they "protect" parents from angry or sad feelings, worrying that it would over-burden them and lead to further rejection (Diamond & Siqueland, 1998). Consequently, adolescents express anger about

these core attachment failures and restricted psychological autonomy indirectly through irritability and conflicts over day-to-day behavioral problems (e.g., chores, curfew, etc.; Diamond & Liddle, 1996, 1999).

Repairing Attachment

Research increasingly supports Bowlby's assertion that internal working models, although persistent, are open to revision (Bowlby, 1988; Waters, Kondo-Ikemura, Posada, & Richters, 1991). Because real-life interpersonal experience determines the development of internal working models (rather than intrapsychic forces), Bowlby envisioned working models evolving and responding to experience across the life span. Most empirical studies have examined how negative life events (divorce, maternal depression, etc) lead to a discontinuity of secure attachment (see Waters, Hamilton, & Weinfield, 2000). However, several investigators have proposed that improvements in felt security and self-perception can occur within the context of later positive relationships, such as improved parenting, romantic relationships, or therapy (Cicchetti & Greenberg, 1991; Egeland, Jacobvitz, & Sroufe, 1988; Weinfeld, Sroufe, & Egeland, 2000). Main and Goldwyn (1988) characterized this process as "earned security," defined as an individual with negative parenting experiences as a child, yet who has developed a realistic perspective on these events and has come to terms with or even forgiven parents who were cold, unloving, or rejecting. One study found that adults with earned security remain as susceptible to depression as adults with insecure attachment styles but have parenting practices similar to adults with secure attachment thereby providing some protection to the next generation (Pearson, Cohn, Cowan, & Cowan, 1994).

The mechanism for earning secure attachment is less well understood. Life span attachment research primarily focuses on the consequence of internal working models, not how to improve them. Studies on adolescent affect regulation and family interaction have begun to describe interpersonal processes that would be appropriate targets of intervention (Allen, Hauser, & Borman-Spurrell, 1996; Cole-Detke & Kobak, 1996). Kobak and Sceery (1988) point out that while behavioral interactions between parents and children shape early attachment security, given adolescents' emerging cognitive capacity, *conversation* increasingly become the mechanism through which attachment security is experienced and negotiated (Kobak & Duemmler, 1994). Building on this idea, the ABFT model uses conversations directly about relational failures as the key mechanism for earning security.

Many medicinal processes are active in these conversations. First, helping adolescents identify, articulate, and appropriately address these relational ruptures challenges their hopelessness, helplessness, and passivity. Rather than avoiding assertions of psychological autonomy, adolescents are encouraged and coached to appropriately express core concerns and conflicts. This prompts a healthy entitlement and expectation of fairness. In addition, the direct discussion of these attachment failures helps adolescents develop a more coherent and realistic understanding of these events, the key ingredients of earned security (Main & Goldwyn, 1988). For parents, these conversations help them differentiate between adolescents' irritability and legitimate claims of injustice. This ideally increases parents' tolerance for conflict and the adolescents' psychological autonomy (e.g. differentiation). For both parents and adolescents, these conversations become opportunities to increase one's capacity to safely experience and regulate intense emotion, and more generally to acquire the necessary skills to negotiate future assertions of autonomy. If successful, these encounters offer a significant positive experience that can help rebuild mutual trust. In ABFT, like Contextual Therapy, repairing trust and reestablishing fairness between family members is a primary therapeutic goal (Boszormenyi-Nagy & Sparks, 1984).

Working through core relational ruptures has parallels in other therapy models such as interpersonal psychotherapy (Klerman, Weissman, Roundsaville, & Chevron, 1983; Mufson et al., 1999) or Supportive Expressive psychotherapy (Luborsky, 1984). However, in Family Therapy, adolescents resolve interpersonal problems directly with parents (whom are often the perpetrator) rather than through the relationship with the therapist. Although parents may not respond with as much therapeutic accuracy as a therapist, even partial acknowledgment or reparation from a parent for past injustices may have a more profound, existential impact than empathy and support from a therapist (Boszormenyi-Nagy & Krasner, 1986). If we believe that internal working models represent early parent–child interactions centered around attachment-related goals such as protection and comfort seeking (Bowlby, 1969; Main, Kaplan, & Cassidy, 1985), then possibly a profound corrective-attachment experience with one's caretakers (and

ideally sustained improvement in parenting behavior) may have the potency to alter interpersonal schemas about self and other (Weinfeld et al., 2000).

Trauma and Forgiveness

The proposed healing process in ABFT has parallels with models of trauma recovery and forgiveness that should be briefly mentioned. Many of the depressed adolescents in our study experienced physical or sexual abuse, witnessed violence, or reported emotional abuse. They often attribute their depression to these experiences. Herman's model of trauma recovery (Herman, 1992) delineates several steps toward working through these experiences. These steps include helping the patient (a) restore a sense of control, (b) establish safety, (c) tell the trauma story in detail, (d) mourn losses, and (e) reconnect with self and community. ABFT helps family members collaboratively participate in conversations that achieve similar goals.

Forgiveness researchers have also identified similar processes for resolving negative experiences. These processes include (a) experiencing strong emotions, (b) giving up the need for redress from the perpetrator, (c) seeing the offenders as distinct and separate from one's needs and identity, and (d) developing empathy for an offender (Enright, Santos, & Al-Mabuk, 1989; McCullough, Pargament, & Thoresen, 2000; Worthington, 1998). Several individual, family, and couples therapy models have begun to view forgiveness as a core therapeutic process (Gordon & Baucom, 1998; Hargrave & Sells, 1997; Johnson, Makinen, & Millikin, 2001). Although the ultimate goal of AFBT is exoneration rather than forgiveness, these processes characterize many of the therapeutic challenges that family members face in ABFT.

PROPOSED CHANGE MECHANISMS

Based on the theoretical assumptions described earlier, the first half of treatment focuses on helping the adolescent identify and discuss past and present family conflicts or events that have ruptured the attachment bond and damaged trust between family members. Therapists help parents tolerate and acknowledge these disclosures and help them apologize for their contribution to these attachment failures. An apology acknowledges the failure itself, as well as the injustice of ignoring or denying the importance of these disappointments. Acknowledging the adolescents' felt injustice often leads to the adolescent exonerating the parent and a renewed mutual interest in repairing the relationship (Boszormenyi-Nagy & Sparks, 1984). This reattachment process helps diffuse family tension, reestablish the family as a secure base, and liberates adolescents from preoccupation with family conflicts, freeing them to focus on developing autonomy. This initial siding with the adolescents' concerns helps engage the adolescent in the treatment process and diffuses the interpersonal hostility that can impeded therapy (Liddle & Diamond, 1991). In addition, once parents accept responsibility for their contribution to the problem, it gives them a new authority to hold the adolescent more accountable.

The second half of treatment focuses on promoting adolescent autonomy (i.e., improving school performance/attendance, finding a job, developing or returning to social activities, etc.). Success with these activities combats negative self-image, reduces isolation, and restores normative developmental challenges. In addition, these activities can increase one's sense of competence, which can reduce or buffer against further depression (Cole, 1990). With attachment on the mend, parents provide a secure base from which adolescents pursue these activities. During this phase of treatment, parents provide nurturance, support, encouragement, and expectations (Baumrind, 1991) for adolescents as they rebuild their lives.

Table I provides an overview of the treatment model. Target problems refer to seven empirically identified risk factors highly characteristic of this population. These processes have been linked to developmental failure and psychopathology (Gotlib & Hammen, 1992; Kaslow, Deering, & Ash, 1996). Consequently, interventions that remediate these processes should have a powerful and potentially long-lasting effect (Russ, 1998; Shirk & Russell, 1996). Treatment tasks refer to the five intervention strategies used to remedy these problem states. These are complex, multicomponent, yet systematic intervention sequences aimed at a specific goal. Expected outcomes refer to the desired goals of each treatment task. This template of target problems, tasks, and expected outcomes rapidly focuses a therapist on the most essential mechanisms of dysfunction and growth (Vernberg, 1998). First we discuss the empirical support for these problem states, and then the clinical model for addressing them.

Table I. Targets and Proposed Mechanisms of Change

Risk factors	Treatment tasks	Expected outcomes
1) Parent criticism	Relational reframe	Reduce blame/criticism, mutual responsibility
2) Adolescent motivation	Alliance building	Build bonds, identify goals, engagement, increase hope
3) Parental stress	Alliance building	Increased trust, Social supports,
4) Ineffective parenting	Parenting education	Authoritative parenting
5) Family disengagement and conflict	Reattachment	Trust, respect, dependability
6) Affect constriction		Affect regulation
7) Negative self-concept	Promoting competency	Increased autonomy

TARGET PROBLEMS/RISK FACTORS

Criticism and Hostility

Parents often attribute their depressed child's behavior to laziness or oppositionality rather than to depression. These dispositional explanations fuel parental criticism and hostility (Fincham & Bradbury, 1988) and adolescent anger and withdrawal. Ratings of parental hostility and criticism have been associated with children's self-criticism (Jaenicke et al., 1987) and depression in general (Fendrich, Warner, & Weissman, 1990; Sheeber, Hops, Alpert, Davis, & Andrews, 1997). This emotional climate, sometimes operationalized as Expressed Emotion (EE), differentiates clinical from nonclinical samples (Hibbs, Hamburger, Lenane, Rapoport, et al. 1991) and predicts relapse in young persons with both schizophrenic and affective disorders. For example, Asarnow et al. (1993) found a significantly lower rate of recovery for depressed children (aged 7–14) from families with high EE than for children from families with low EE. The difference remained significant even after controlling for exposure to treatment and clinical characteristics. These results mirror the findings in many studies of adult depression (e.g., Hooley, Orley, & Teasdale, 1986). Reduction of EE as a result of treatment also prevents relapse (Doane, West, Goldstein, Rodnick, & Jones, 1981). The relational reframe task focuses on reducing criticism by introducing a strengths-based systemic view of both the problem and the solution.

Adolescent Motivation and Engagement

Apathy and anhedonia compromise developmental success and treatment engagement. Depressed adolescents lack motivation and optimism and consequently withdraw from activities that once gave them pleasure (Feather, 1983). Hopelessness, passivity, and low self-agency debilitate these youths, frustrate peers, parents, and teachers, and lead to school failure, social isolation, and often suicide. Low motivation presents particular problems for engaging adolescents in treatment (Diamond & Siqueland, 1998). As with many youths, these patients are rarely self-referred and often resistant to treatment (Koocher, 1976). They enter treatment with low expectations for change and high expectations of being criticized and blamed. Given the negative impact of hopelessness, the alliance building task with the adolescent alone specifically targets this deleterious process.

Parental Stress

Living with a depressed or psychiatrically distressed parent has a serious impact on child functioning. Researchers have reported a threefold increase of any diagnosis and a sixfold increase for major depression for children with depressed parents in comparison to normal controls (Goodman & Gotlib, 2002). Cole and Rehm (1986) noted a 60% concordance rate between mother and child diagnoses of depression. Although the actual mechanism of transmission is not fully understood, genetics, poor attachment, and marital conflict may all contribute to children's problems (Downey & Coyne, 1990). From a treatment standpoint, parental depression seriously impedes therapy progress. Distressed parents are more defensive, withdrawn, and preoccupied (Gladstone & Beardslee, 2002). Thus, Task 3, parent alliance building, focuses on linking parental stress with current family conflict and on providing or referring parents for help.

Ineffective Parenting

Parenting practices is a potent mechanism through which parental depression may effect

children. As Coyne, Downey, and Boergers (1990) note, parenting requires sustained and effortful interaction, negotiation of skills, flexibility, sensitivity, planning, problem solving, and the ability to be authoritative without being authoritarian. Parental depression and other stressors undermine these qualities. Diagnosably depressed mothers are less effective in managing their children, offer less structure and involvement, and are more negative in their emotional expression than nonclinical mothers (Goodman and Brumley, 1990; Hammen, Burge, & Stansbury, 1990). Interestingly, Downey and Coyne (1990) argue that life stress, marital discord, and lack of social supports may mediate the impact of a depressed adult's parenting. Even in the absence of parental psychopathology, overcontrol and directiveness are associated with internalizing disorders in childhood (Hetherington & Martin, 1986; Rubin & Mills, 1991; Parker, 1983) and with depressive symptoms in adolescents (Gallimore & Kurdek, 1992; Radziszewska, Richardson, Dent, & Flay, 1996). In addition, parental conflict over parenting practices and involvement of the child in the conflict are also associated with childhood depression (Cummings & Davies, 1994; Puig-Antich et al., 1985). Helping to rebuild effective parenting skills is a primary goal of the alliance building task with the parent.

Disengagement

Depressed adolescents often feel isolated and disconnected from parents. Under the cloud of depression, adolescents view their parents as psychologically unavailable, nonaccepting, and rejecting (Kaslow, Rehm, & Siegel, 1984; Lefkowitz & Tesiny, 1984; Stark, Humphrey, Crook, & Lewis, 1990; Stark, Humphrey, Laurent, Livingston, & Christopher, 1993). Compared to nonclinical or other psychiatric groups, depressed and suicidal children perceive their families as less supportive and less cohesive (Asarnow, Carlson, & Guthrie, 1987), and both their families and peers as less trustworthy and dependable (Armsden & Greenberg, 1987). While this perception may be a function of the depression, it may also reflect actual family dynamics. For example, many parents become emotionally and behaviorally overcontrolling of a depressed adolescent, resulting in a suppression of the adolescent's self-expression and autonomy (Amanat & Butler, 1984). When frustrated, parents become more negative, critical, detached, and punitive (Burbach & Borduin, 1986), thereby reinforcing the depression. Therefore, rebuilding an emotional family bond is the primary goal of the entire first half of treatment, specifically the reattachment tasks.

Emotion Regulation

Researchers have found that depressed individuals have difficulty regulating emotion and, in particular, managing negative affect. For example, depressed adolescents and adults stay longer in negative mood states and have limited or ineffective strategies for regulating affect (Garber, Keiley, & Martin, 2002; Gilboa & Gotlib, 1997; Sheeber, Allen, Davis, & Sorensen, 2000). Eisenberg, Fabes, and Murphy (1996) found that children who received negative reactions to their negative emotions tended to use avoidant rather than problem-solving strategies to resolve these feelings. In contrast, when mothers used problem-solving reactions to children's negative emotions, the children showed less negative emotion. Sheeber, Hops, Andrews, Alpert, & Davis (1998) found that in problem-solving interactions, mothers of dysphoric adolescents were more likely to increase facilitative behaviors while fathers of dysphoric adolescents were more likely to decrease aggressive behavior after adolescent depressive behavior. These and other studies have increasingly suggested that children raised in families that have difficulty de-escalating negative emotions may not learn effective strategies for regulating their own emotions (e.g., Lindahl & Markman, 1990). Alternatively, family environments that promote an acceptance of emotions and their expression as well as actively teaching and modeling how to manage difficult emotions can help children develop these emotion regulation abilities (Gottman, Katz, & Hooven, 1996). Improving affect regulation is again an overarching goal of ABFT with a particular focus during the reattachment task.

Negative Self-Concept

Self-denigration and feelings of worthlessness make depressed teens feel unworthy of love, attention, and support. This is self-defeating for teens and frustrating for parents, whose attempts to motivate the adolescent are perceived as controlling or critical. Negative self-perception is a centerpiece in many theories of depression (Beck, 1967; Rehm, 1977).

Depressed children and adolescents report less self-worth and feel less competent in academics, sports, physical appearance, personal conduct, and social functioning than their nonclinical counterparts (e.g., Cole, 1990; Harter, 1990). Real-life circumstances often reinforce this view. Compared to a nonclinical sample, peers perceive depressed youths as socially isolated, less active, less assertive, more submissive, more impulsive, and more often rejected (Altmann & Gotlib, 1988; Peterson, Mullins, & Ridley-Johnson, 1985).

Recent research, primarily with younger children, suggests that negative cognitive styles may develop from parent–child interactions. For example, fathers' critical statements to children in problem-solving interactions were associated with children's self-denigrating comments (Hamilton, Asarnow, & Tompson, 1999). In addition, when parents' styles induce guilt or excessive feelings of responsibility for others, children are at a higher risk for depression (Donenberg & Weisz, 1998; Thompson & Calkins, 1996; Zahn-Waxler, Cole, & Barrett, 1991). Even Beck proposed that the origins of depressgenic thinking stem from early family relationships (Beck, 1967). The competency building tasks helps family members collaboratively identify and challenge negative self-schemas and find activities that will promote competency and positive self-esteem.

THE FIVE TREATMENT TASKS

On the basis of the aforementioned theoretical models, developmental research, and clinical experience, we have developed five essential treatment tasks to target these seven problem areas. Tasks represent distinct episodes of therapeutic work characterized by specific intervention strategies to resolve specific problem states (Rice and Greenberg, 1984). Tasks serve as templates through which therapists organize information and make decisions about the goal and focus of therapy, putting shape, meaning, and direction to treatment sessions. Tasks also have an internal logic to them that help move family members toward specific goals. To provide a clear conceptual map and a session-by-session treatment plan, we present each task as a discrete event delivered in a sequential order. However, each task builds on previous ones, interacts with other tasks and may get reworked over and over again (Diamond & Diamond, 1999). More detail on each these tasks is provided in other cited papers.

Task 1: Relational Reframing

This task sets the foundation of treatment by establishing improvement in family relationships as the primary initial therapeutic goal (Diamond & Siqueland, 1998). Parents of depressed adolescents often enter treatment frustrated that their many attempts to help the adolescent have failed. Adolescents enter treatment unmotivated, denying problems and wanting to solve things themselves. They also interpret parents' helpfulness as criticism. This leads to a cycle of parents reaching out, adolescents rejecting help, parents becoming frustrated, and adolescents feeling criticized. The therapist capitalizes on the parents' concern and the adolescent's feeling misunderstood, to initiate the relational reframe. Essentially, the therapist offers to help the parent find more successful ways to communicate with the adolescent and to help the adolescent express his or her concerns in ways that will be respected. This reframing removes the sole burden of change from the adolescent and redistributes it to all family members. In addition, it emphasizes family strengths over deficits, which helps reduce blame and criticism.

The success of the relational reframe rests on the establishment of several subthemes. After the traditional first session activities (e.g., joining, history taking, etc; Haley, 1987) the therapist helps the adolescent describe his or her depression or unhappiness. In this way, the therapist uses the seriousness of the disorder as the rallying point around which to motivate family members to try new behaviors. The therapist then attempts to generate a softer, more compassionate emotional tone to the conversation. To accomplish this, the therapist elicits from both the adolescent and the parent(s) sentimental remorse about the distance and conflicts that have arisen between them because of the depression (e.g., "So I would guess that you miss each other" or "You never thought it would be like this"). With this foundation set, the therapist can ask the parent the pivotal question—"When your child feels so bad, like killing herself, why doesn't she come to you for help? What is getting in the way of you being a resource to her?" This question redirects the conversation away from symptom description or history taking and onto events and processes that have damaged trust and communication. These conflicts may be as benign as parent overprotectiveness or as egregious as abuse and abandonment.

Having established the adolescent's misery, distancing conflicts between the family members, yet

their desire for connection, the session culminates with the suggestion that focusing treatment on repairing this parent–child schism would reduce tension, improve communication, and provide greater security for the adolescent. Often the therapist strengthens this clinical framework with a family friendly version of the theory that has been presented above. At minimum, a therapist hopes the family members will consider this treatment goal and discuss it more in future sessions. Most importantly, the family must experience this challenge as a promotion of strengths and not an assertion of blame.

Task 2: Alliance Building With the Adolescent

Bordin's tripartite model (Bordin, 1979) of alliance (bonds, goals, tasks) provides a heuristic structure for the alliance building task with the adolescent. Generally done in a meeting alone with the adolescent, the first phase of this task focuses on building a bond. The therapist begins by showing interest in the adolescent's social context and worldview (Liddle, 1999). Assessing and identifying strengths, competencies, hobbies, and resources amplifies aspects of the adolescent's life that have often been ignored by the parents (Micucci, 1998).

Phase two of the task focuses on defining treatment goals that are meaningful for the adolescent (Diamond, Liddle, Hogue, & Dakof, 1998) and will set the foundation for the reattachment task. The conversation turns to identifying current and longstanding problems between the adolescent and the parent(s). Generally, adolescents will complain about (a) neglect, abandonment, or abuse, (b) being triangulated in marital conflicts, (c) feeling parentified (e.g., being the emotional or physical caretaker of a sick family member), (d) unmourned grief over the loss of a family member, a relocation, or their own health problems, or (e) a general sense of feeling unloved and unappreciated. These discussions help the adolescent identify, articulate and emotionally process the thoughts and feelings about these core, often avoided, concerns.

Phase three of the alliance task focuses on getting the adolescent to agree to participate in the reattachment task. This phase begins with asking adolescents why they have not shared these concerns with their parents. Typically, adolescents are hopeless about change or too protective of their parents to criticize them. Depressed adolescents don't expect change and are preoccupied with rejection. The therapist explores and challenges these beliefs in order to help the adolescents develop new cognitive and affective skills necessary for effectively negotiating autonomy. As the adolescents' skills and healthy entitlement grows, the therapist challenges and coaches him or her to communicate more effectively (e.g., less sarcasm and passivity and more honesty and expectation of accountability). Adolescents' willingness to try these new interpersonal skills partially depends on them trusting that the therapist can protect them from potential parental rejection and criticism.

Task 3: Alliance Building With the Parent(s)

In a meeting alone with the parents, the therapist begins by exploring aspects of the parents' lives that are independent of the adolescent (Diamond, Diamond, & Liddle, 2000). This conversation may focus on strengths (e.g., work, hobbies, and social network) as well as vulnerabilities (e.g., psychiatric problems, stressful life events, or marital conflict). The therapist also focuses on intergenerational themes by asking about the parents' relationship with their own parents. Although historical conflicts do not get resolved in this task, helping parents examine their own history of relational disappointment increases their motivation to protect the next generation from similar injustices (Boszormenyi-Nagy & Sparks, 1984; Pearson, Cohn, Cowan, & Cowan). In addition, these conversations help illuminate parents' theories and attitudes about emotional expression. Parents' metaemotion philosophy (Gottman et al., 1996) then becomes a focus of discussion and change. If both parents are in the session, parental teamwork is often a focus of conversation as well. This first phase culminates with an exploration of how these themes (e.g., stress, family history, metaemotions, parenting conflict) might complicate the already difficult task of parenting a depressed adolescent (Belsky, 1984; Dadds, Schwartz, & Schwartz, 1987). The therapist must also convey confidence that this conversation can be successful.

With this foundation set, the therapist begins to focuses on the parents' commitment to the reattachment task and preparation for its implementation. This phase often begins with a version of the following statement: "OK. Here is what I want to do next. I think your daughter has things on her mind that you need to hear. They might be hurtful when you hear them, but until she gets them off her chest and feels that you understand her, she may not trust you

again. Are you willing to listen to these concerns?" This challenge may provoke resistance. For instance, parents may suspect that the therapist blames them for the adolescent's depression, or protest that they have tried this before, but the adolescent refused to talk. In response, the therapist assures parents that this process is not about blame, but about helping the adolescent develop the entitlement and interpersonal skills to address these felt injustices (Boszormenyi-Nagy & Sparks, 1984).

If parents accept this rationale, the therapist prepares them for the reattachment task. Essentially, the therapist teaches the parent listening skills similar to the emotional coaching skills outlined by Gottman et al. (1996) and the affective parenting skills described by Faber and Mazlish (1980). These skills include accepting strong emotions, empathic listening, and validating and labeling feelings. Essentially these skills help parents listen to their adolescent's complaints, ask questions, be curious, and not become defensive or try "to fix" things. The success of the reattachment task is dependent on the parent understanding and using this skill set in the upcoming conjoint session. If the parent is not ready, more time can be spent setting this foundation. If the parent is ready, the therapist can explore parents' fears and worries about this conversation and plan for what might go wrong.

Task 4: Reattachment

This task (Diamond & Stern, 2003) builds on the foundation established in previous tasks. Previous sessions have developed new problem and solution attributions, established strong alliances with all family members, identified core conflictual themes, and solidified the commitment to engage in this dialogue. With this foundation, the therapist initiates a conversation between family members about the core relational failures. If the foundation is unstable, the therapist may postpone the enactment of this conversation. Alternatively, the conversation itself may solidify the foundation.

The reattachment task begins with the therapist or the parents encouraging the adolescent to express his or her grievances (Diamond & Stern, 2003). The therapist challenges the adolescent to be direct, while encouraging the parents to be patient and receptive. Many parents welcome these specific complaints over indifference and withdrawal, even though they can be hurtful. In fact, if adolescents can maturely express claims of injustice, many parents experience remorse and empathy (Diamond & Liddle, 1996). As the adolescent feels acknowledged and safe, feelings of anger and vengeance often give way to sadness, fear, and disappointment. Parents' acceptance and understanding of these claims and vulnerable emotions, reinforces the adolescent's healthy entitlement and new interpersonal skill set.

Adolescent monologues increasingly give way to parent-adolescent dialogues. Parents may tell their side of the story, talking about their drug use, history of marital abuse, or their own depression. These stories are not intended to defend the parent or burden the adolescent. In contrast, appropriate mutual sharing creates a moment of mature intimacy, as if two adults were sharing their tragic life stories. Ideally, this conversation leads to mutual respect for each other's experiences, shared responsibilities for past failures, and a common commitment to future growth.

While these multiperson dialogues are more ambitious than individual therapy, family therapists leverage one family member's momentary maturity and growth to motivate similar development in others. When a rejecting adolescent becomes vulnerable, an angry parent becomes empathic. When a blaming parent apologizes, a defensive adolescent accepts more responsibility. In general, the impact of an authentic emotional and ethical encounter between family members can bring out the best in people.

The reattachment task serves several goals. First, it engages adolescents into therapy by addressing the concerns that are important to them (Liddle, Dakof, & Diamond, 1991). This is not a minor accomplishment. Second, it gives adolescents a positive experience with asserting autonomy. Third, it creates an opportunity for the learning and practicing of new communication and conflict resolution skills. Fourth, even partial resolution of these hot topics helps to modulate negative feelings and attributions that inhibit family cohesion and age-appropriate attachment. Resolution of these conflicts may not directly reduce depression. It does, however, dissipate the tension and hostility that inhibits trust and communication, and gives the family a positive experience of adolescent psychological autonomy. Thus, the reattachment task clears the way for a new opportunity for family support and connection, which can buffer against depression.

Task 5: Promoting Competency

The fifth treatment task focuses on promoting the adolescent's perceived and actual competency. The

three primary goals of this task are to (a) increase the quantity and quality of competency experiences, (b) decrease social isolation, and (c) help parents become an effective resource for the adolescent. During this task, the therapist increases his or her attention to behavioral and organizational change, both inside and outside of the home. These behavioral changes are supported by the interpersonal strengths and skills developed in the first half of treatment. In fact, focusing on the resolution of current behavioral problems provides a context for using the newly found trust and mutual respect experienced in earlier sessions. In particular, the therapist now encourages parents to appropriately challenge and support the adolescent to become more motivated and accountable. Similarly, the therapist encourages adolescents to stop blaming their parents, take their lives more seriously, and accept greater responsibility for their behavior. In this context, family members practice and solidify their new interpersonal skills, competencies, maturity, and trust while working through the more concrete behavioral problems of life. Therefore, this task requires the therapist to keep his or her eye on both interpersonal processes (e.g., how family members talk to each other) and behavioral goals (e.g., returning to school).

The therapist encourages the family to discuss and develop expectations about normative activities such as chores, curfews, dating and allowance, as well as problems related to school, peers, violence, drugs, relationships, and sex. Parents are encouraged to support adolescents' small steps toward autonomy and competency (e.g., new clothes, hairstyles, make-up, ear piercing, etc.). Because depressed adolescents are often out of step with their peer group, supporting age-appropriate behavior can help them feel more adjusted. Within limits, the therapist encourages parents to show interest in the adolescent's activities without being over involved or controlling (e.g., adolescent teaches parent about rock and roll music). Simultaneously, parents must become less tentative about setting appropriate goals and expectations. Without expectations, adolescents have no standards or vision (Baumrind, 1991). But the expectations need to be realistic. For some adolescents, remaining in an honors program or even finishing school may be a self-defeating goal. Ideally, the adolescent should be involved in the negotiation of these decisions and plans. This enhances confidence, communication skills, and a sense of agency.

An important step in promoting competency is to increase or improve the quality of the adolescent's (and parents') connections to social supports or resources. Especially in the context of a brief treatment, therapists must make immediate contact (often within the first week) with important extended family members, school personnel, and social service providers (e.g., probation officers and social workers). These support systems provide a broader, ecological context to the case and assist in identifying important treatment goals. The therapist may invite important persons to attend a session, go on a home or school visit, or keep other professionals updated by phone. Whenever possible, adolescents and parents should participate in planning these larger systems interventions. Adolescents should take an active role in these events and not be a bystander. Parents should advocate for their adolescent while continuing to appropriately challenge him or her.

CONCLUSION

The desired outcome of the ABFT is that parents become a safe and secure base to which the adolescent can turn for comfort, support, and guidance. Adolescents begin to see parents as a source of support and encouragement and parents begin to help their child without being critical or controlling. Within this new family context, parents and adolescents negotiate new rules and expectations about relationships, daily behaviors, and autonomy both inside and outside the home. Parents use a more authoritative parenting style (Baumrind, 1991) and adolescents use more mature and direct communication. Parents then can remain a secure base for adolescents while they rebuild the personal and social life that depression has damaged.

EMPIRICAL SUPPORT

Treatment Outcome

The first randomized clinical trial of ABFT has been completed (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002). Thirty-two adolescents, between the ages of 13 and 17 (mean = 15, $SD = 1.5$), were randomized to 12 weeks of ABFT treatment or 6 weeks of wait-list. 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 6 months prior to treatment, 14%

of adolescents 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. According to parent report on the Child Behavior Checklist (Achenbach, 1991), 47% of the sample was above the clinical cutoff for delinquency and 30% for aggressiveness, indicating a high degree of comorbid externalizing behaviors. Finally, using the Brief Symptom Inventory (Derogatis & Melisaratos, 1983) to describe their own psychiatric distress, parents reported clinical levels of depression (42%), anxiety (47%), and hostility (37%).

Engagement in Treatment

One hundred percent of patients completed posttreatment assessments. Nineteen percent attended all sessions, 44% attended 9–11 sessions, 24% attended 5–8 sessions, and 13% attended 3 sessions.

Outcome and Effect Sizes

Of the 16 treatment cases, 13 (81%) no longer met criteria for MDD posttreatment, while only 9 (56%) of the patients on the waiting list no longer met criteria for MDD post–wait-list, $\chi^2(1) = 4.05$, $p < .04$. Though there were not significant differences between the groups on mean BDI score posttreatment, there was a significant treatment condition difference noted in the number of adolescents who had posttreatment BDI scores in the nonclinical level, BDI < 9, $\chi^2(1) = 6.37$, $p = .01$. 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 6-month follow-up data on diagnosis is also very promising. Because the original study design did not include 6-month follow-up, assessments were started halfway through the trial. Using a combined sample of 25 families treated with ABFT (original treatment group and patients treated from the wait list who still met entrance criteria), we assessed 15 families at 6 months posttreatment. Thirteen (87%) of these 15 adolescents did not meet criteria for MDD. Table II shows the means and standard deviations, *F* scores, *p* values, and effect sizes for each measure completed by the patient. Planned comparisons (Group × Time) indicated that, compared to the 6-week wait-list, 12 weeks of FT was associated with significant reduction in depression (HAM-D), anxiety (STAIC), and Family Conflict (CON). FT also yielded nearly significant changes in attachment to mother (IPPA-M), hopelessness (BHS), and suicidal ideation (SIQ).

Table II. Results of the ABFT Pilot Study

	Treatment				Control group				Planned comparison		
	Pre		Post		Pre		Post		Group × Time		
Child	*M*	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*	*F*	*p*	*ES*
Symptoms											
BDI	23.8	7.4	10.4	9.8	28.0	7.1	18.5	11.1	—-	—-	—-
HAM-D	20.1	5.6	10.3	8.7	17.0	7.0	15.3	6.7	9.3	.005	1.21
STAIC	43.9	6.0	38.2	7.6	43.2	5.1	45.7	6.6	8.6	.007	1.24
SIQ	34.2	21.8	21.0	16.6	30.0	19.3	28.3	22.0	3.1	.09	.52
BHS	11.7	5.6	6.2	5.5	11.4	5.9	10.4	5.9	3.4	.08	.78
YSRInt2	65.4	9.3	56.4	10.8	63.8	10.5	66.6	8.4	—-	—-	—-
YSRExt2	57.2	10.0	52.6	10.1	60.2	8.9	57.6	9.7	—-	—-	—-
Family											
COH	13.4	2.8	14.4	4.4	13.1	3.5	14.1	3.7	—-	—-	—-
EXP	12.3	3.1	14.7	3.3	11.9	3.6	13.1	2.7	—-	—-	—-
CON	13.6	3.1	9.4	3.5	14.3	3.6	13.6	2.9	5.2	.03	1.21
IPPA-M	80.1	22.4	90.4	20.2	80.7	19.0	76.8	22.6	3.6	.07	.63

Note. BDI = Beck Depression Inventory; HAM-D = Hamilton Depression Rating Scale, IPPA-P = Peer-Adolescent Parent and Peer Attachment; STAIC = State-Trait Anxiety Inventory for Children; SIQ = Suicidal Ideation Questionnaire, BHS = Beck Hopelessness Scale, YSRInt = Youth Self Report Internalizing Subscale; YSRExt = Youth Self Report Externalizing Subscale, COH = Cohesion Subscale for Self Report of Family Functioning; EXP = Expression Subscale for Self Report of Family Functioning, CON = Conflict Subscale for Self Report of Family Functioning; IPPA-M = Mother—Inventory of Parent and Peer Attachment.

Treatment Adherence

In light of the promising outcomes, we sought to test treatment integrity and differentiation. Integrity measures the degree to which the model was delivered as outlined in the manual (Yeaton & Sechrest, 1981). Discriminability measures the degree to which the treatment differs from other treatment conditions (Hogue et al, 1998; Startup & Shapiro, 1993). Data regarding the integrity and discriminability of an applied treatment have important implications for interpreting outcome results and exploring the therapy process.

We examined 45 full-length videotaped sessions of ABFT, cognitive–behavioral therapy for adolescent drug abusers, and multidimensional family therapy for adolescent substance abusers—135 sessions in all. These tapes were drawn from two separate randomized clinical trials (Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Liddle et al., 2001). Coders rated therapists' interventions during each session, using the Therapeutic Behavior Rating Scale – 3rd version (TBRS-3; Diamond, Hogue, Diamond, & Siqueland, 1998), an observer-based instrument designed to measure the extent to which therapists employ each of 20 discrete therapist interventions over the course of a therapy session.

Results indicated that ABFT was implemented in a manner consistent with its prescribed theoretical tenets and intervention strategies (Diamond et al., 1998.) Specifically, ABFT therapists encouraged the identification and expression of affect, worked to restructure the family, and promoted adolescent–parent attachment. Furthermore, ABFT could be discriminated from cognitive–behavioral therapy.

PROCESS RESEARCH

The theoretical/clinical model and the initial empirical support described above provided the essential foundation for validating a new treatment. However, investigators have become increasingly interested in better understanding and testing the proposed processes of change and change mechanisms. Investigations at this level provide both a test of the basic tenets of a model (e.g., Are the proposed active ingredients of treatment present and effective?) and help embellish and refine one's understanding of moment by moment treatment process essential to successful implementation (Kazdin, 1997; Shirk & Russell, 1996). These studies generally use quantitative and qualitative methods to move back and forth between theory, clinical experience, and empirical description. See Greenberg and Pinsoff (1986), and Rice and Greenberg (1984) for more detail about methodologies for these kinds of studies. Toward this goal, we have completed and are working on several process research studies.

Attributional Shifts During the Relational Reframe

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." First, we wondered if these families came to treatment with an interpersonal construction of the problem and, if not, did the relational reframe help them develop one? On the basis of the couples attribution literature, and particularly the work of Fincham and Bradbury (1988), we developed a parent and adolescent, pre- and post-session, self-report questionnaire to assess changes in clients' view of responsibility for causing and correcting the problems that brought them to treatment. First, two open-ended questions were asked: "What problems brought you to therapy?" and "What do you think is causing these problems?" Then the parent and the adolescent rated themselves and each other on how much each person contributed to the problem, and how willing, capable and responsible each person was for solving these problems. They were also asked how much conflicts between them (parent-adolescent) contribute to the problem. Each item was rated on a 1–5 scale from *not at all* to *completely agree.* All items were rated prior to and immediately after the first session.

The questionnaire was given to consecutive families at the first treatment session at a community mental health clinic where the first author was the Outpatient Director. 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 the solution, and therefore would need guidance in approaching the treatment from this perspective.

Because the families generally rated themselves high pretreatment on having an interpersonal construction of the problem, the measure was not sensitive to postsession change. Therefore, we interviewed eight parents after the first session using a videotape recall method (reviewing selected key therapeutic moments; Elliot, 1984). Among other things, parents approved of our initial siding with the adolescent, but expected more equanimity in later sessions. Parents did however like the treatment focus. A few parent comments are provided below.

Mother about daughter. "The most important aspect of the session was my daughter finally expressing herself, even though it hurt me deeply to hear that she does not feel connected to me."

Father about daughter. "It really struck home that this is not just adolescent blues, but a serious problem in our relationship. I was shocked, but the therapist opened up my heart."

Stepfather about son. "I think my son felt that his depression was a disappointment to us. But we got through to him. He now knows that he can talk to us, and that we're not going to abandon him. He can't scare us away."

These 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 cognition's 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.

Relational Reframe in Parent Alliance Task

Therapy is a cyclical process of progress and setbacks, where clinical themes are set out, worked and reworked (Liddle, 1999; Prochaska & DiClimente, 1982). Therefore, we were interested in identifying which therapist interventions led to and maintained a relational focus. Specifically, we were interested in whether a parents' shift in problem attribution persisted after the reframing intervention, or if they reverted back to a more individual problem focus (e.g., my daughter has to change). Further, we were interested in if and why therapists interventions changed over the course of sessions. Therefore, we examined the effect of therapists' use of the relational reframe on clients' subsequent cognitive constructions of their problems during the parent alliance building session (Task 3; Moran, Diamond, & Diamond, 2002). Three separate good-alliance sessions were selected based on scores on the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983). Relational reframe interventions were then measured across the entire session, using the ABFT adherence scale modified to rate each therapist statement. Parents' problem construction statements were rated as interpersonal (between people) or intrapersonal (within the adolescent or the parent) using the Cognitive Constructions Coding System (CCCS; Friedlander & Heatherington, 1998).

The first finding, which supports the qualitative study described above, was that in all three cases, parents began the session with primarily intrapersonal problem constructions (e.g., it is the adolescent's fault). As the session progressed however, we observed a proportional increase in interpersonal problem constructions focused on the parent–adolescent relationship. Second, probability analysis indicated that therapists' relational reframes clearly led parents to shift toward interpersonal problem constructions. Lag analysis indicated that this effect persisted for up to five subsequent problem constructions. Furthermore, clients' interpersonal problem constructions also predicted therapists' subsequent use of the relational reframe. This effect also persisted over time. Further analysis suggested that the correlation between the relational reframe could be accounted for, at least in part, by two mechanisms. First, the reframe led to *shifts* in clients' cognitive constructions (from intrapersonal to interpersonal). Second, the reframe appeared to *maintain* the interpersonal cognitive set of the client. These results suggest that the relational reframe is effective in creating and maintaining the interpersonal frame central to ABFT.

Alliance Building With the Adolescents and Parent

Given the importance of building alliance with each family member, we were interested in understanding 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. The ABFT items were designed to assess two components: how completely goals were discussed and agreed upon, and the extent to which the client or therapist initiated the treatment goals. Goals for the individual parent or adolescent as well as goals for family change were separately identified and assessed. Items were rated on a 1–5 scale from *not at all* to *very much*. Trained blind raters viewed entire sessions.

This study demonstrated that observers can be trained to reliably rate and agree on alliance in family therapy and that alliance with adolescents and their parents are relatively independent and uncorrelated. Factor analysis of the VTAS suggested a separate bond and goal/task factors, especially for adolescents. The VTAS bond factor of adolescent alliance was significantly correlated with number of sessions ($r = .42$, $p = .05$), but the VTAS goal/task factor was not. The ABFT items were not significantly related to retention.

For the adolescents, none of the ratings of VTAS were significantly correlated with depression outcome but there was a trend toward association between alliance and a decrease in parent–adolescent conflict ($r = -.48$, $p = .06$). For the ABFT specific items, there was a trend ($r = .43$, $p = .06$) for adolescent agreement on individual goals to be associated with change in self-reported depression (pre to post BDI change). 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 ($r = .58$, $p = .02$), 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.

Among other things, we found that when the therapist initiated the goal of improving family functioning, adolescents reported improvement in both cohesion ($r = -.51$) and perceived attachment to parents ($r = -.55$). Therapist initiation refers to the therapist proposing a relationship focused treatment goal, stressing why it matters, and proceeding to address these themes even if the adolescent initially resists. This finding suggests that if the therapist retains his or her focus and the therapeutic framework 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

To better understand the actual therapeutic processes that lead to good alliances with parents, we conducted a Task Analytic study of the therapist–parent alliance task (Diamond, Moed, Diamond, & Shelef, 2002). Task analysis (Rice and Greenberg, 1984) is a discovery-oriented, hypothesis generating methodology that involves the use of theory, qualitative analysis, and objective, empirical ratings to arrive at detailed working models of core clinical mechanisms. 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 (line by line transcript exegesis) 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.

Stage 1, *Bond and Acknowledgment*, consists of the therapist showing interest and concern and acknowledging the patient's strengths and accomplishments. Stage 2, *Bond and Empathy*, involves focusing on the personal obstacles and challenges parents faced in their own life (e.g., trauma, abandonment, distress, etc.). During this stage, there is an increase in therapists' use of interventions directed at eliciting vulnerable emotions. Stage 3, *Relational Reframe*, involves exploring the quality of the parent–adolescent relationship and its impact on the adolescent's wellbeing. During this stage therapists introduce core relational themes and continue to elicit vulnerable emotions. Client behaviors are characterized by a proportional increase in moments of peak experiencing and by a shift in cognitive problem constructions from intrapersonal to interpersonal.

Stage 4, *Setting Goals and Tasks*, involves defining and working on the goals of therapy. In the good alliance sessions, this translated into defining parent–adolescent attachment as a principle goal

of treatment and preparing for the subsequent reattachment task. As with Stage 3, in Stage 4 therapist emphasized interventions targeting vulnerable emotions, core relational themes, relational reframes and client's continued to construct their problems as interpersonal in nature. Stage 5, *Bond and Acknowledgment*, involves reinforcing the parent's strengths and abilities. This acknowledgment increases parents' self-efficacy and motivation to attend to their adolescents' concerns. 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 very 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.

Reattachment Task

We have conducted one process study on the attachment task (Stern & Diamond, under review). We were interested in better understanding the client behaviors or "performance" that characterize their progression through the process of confronting and ideally resolving attachment failures. Like the parent alliance study described earlier, this study used a Task Analysis approach (Rice & Greenberg, 1984). First we performed an intensive descriptive analysis of one attachment task rated as very successful by two trained objective raters. This qualitative analysis yielded nine core clinical themes or processes best characterized in three general stages. Next, three successful reattachment tasks and one unsuccessful task were transcribed and coded with trained and reliable raters using the Structural Analysis of Social Behavior (SASB; Benjamin 1974, 1984). Although too complex to describe in full, SASB codes behaviors on three levels: focus on self, other, and intrapsychic. Within each level there are two dimensions. The affiliation dimension ranges from extremely loving to extremely attacking or rejecting. The differentiation dimension ranges from extremely well-differentiated to extremely enmeshed. SASB codes were compared within and between the three clinical stages as well as used to map the entire treatment session.

In brief, the first stage, adolescent disclosure, consisted of five clinical themes: initiation of the task (therapist behavior), adolescent anger, adolescent vulnerable emotions, and adolescent cognitive attributions. In this stage, the adolescent remained primarily focused on him or herself, disclosing thoughts and feelings about current or past relationship failures, while the parent remained interested and focused on the adolescent, asking for more details and avoiding denial or defensiveness. Parents' acknowledgment of the adolescent's experience (often for the first time) diffuses the adolescent's hostility, making way from more vulnerable emotions and grieving.

The second phase, parent disclosure, consisted of a brief parent disclosure and often an apology. This disclosure was not given as a rebuttal, but rather as an honest recognition of personal vulnerabilities that inhibited the parent from making better choices (i.e., "I was too scared and depressed to stop your father from beating me"). As the parent stopped protecting the adolescent from the truth (that they often knew anyway), the adolescent gained a new understanding of the parents' behavior and developed more perspective and compassion about their parents' limitations. These processes were a critical feature of all successful reattachment tasks.

The third stage, parent–adolescent dialogue, consisted of four themes: adolescent ambivalence and deeper vulnerable emotions, relational reframing, exoneration, and wrap up. In this stage, a new kind of reciprocity emerged as the parent and adolescent gained a better appreciation of each other's experiences, struggles, and vulnerabilities. The adolescent became more able to express a fuller range of feelings, and both adolescent and parent were encouraged to see how these experiences or resulting disconnections contributed to current adolescent

functioning. The more the adolescent felt understood and acknowledged, the more they forgave their parents for past injustices. However, the more they came to understand their parents, forgiveness evolved into exoneration.

CONCLUSIONS AND FUTURE DIRECTIONS

This series of process studies have helped us develop, elaborate, and refine the treatment model described in the earlier part of this paper. We identified important relational themes, defined important therapeutic goals, developed the role of emotional processing, and articulated sequences and content of core therapist interventions. Thus far, our attention has been on developing moment-by-moment clinical descriptions or maps of the ideal implementation of each individual task. This has helped us dissect and operationalize complex clinical events into step-by-step procedures that can be easily learned and replicated. In addition, several of the core mechanisms (shifts in attributions, alliance, deepening of emotion, conflict resolution, trust building) can now be measured with a standardized coding system. Our goal now is to apply all these measures to each task across the entire course of treatment. This would allow us to examine the interaction of these processes within task and over time (Diamond & Diamond, 1999). For example, comparing successful and unsuccessful cases (reduction of depression), how does alliance and attributional shifts interact over time and support the success of the reattachment task? Such investigations would continue to illuminate important clinical decision rules and actually test how essential these mechanisms are to ABFT and to treatment outcome.

Along with more process research, we intend to conduct future clinical trials with larger sample sizes to more fully evaluate the efficacy of this model. In addition, we are working on modifying ABFT to address the needs of anxious adolescents (Siqueland, Rynn, & Diamond, 2002) in combination with individual cognitive–behavioral treatment. Other clinical trials are underway or in preparation applying ABFT to depressed adolescents with psychotic features and adolescents with co-occurring depression and substance use disorders. Although each of these disorders present with unique individual and family characteristics, we find that the task structure of the ABFT model and many of its core constructs (e.g., alliance, reattachment) have relevance for these adolescents and their families as well.

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