Adaptation Research in Attachment-Based Family Therapy

Chair and Discussant:
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Introduction

• Tremendous efforts toward developing treatments that target empirically-defined risk factors for specific psychiatric disorders among youth

• Less attention has been given to adapting well-developed models for culturally diverse families

• Even less attention devoted to the adaptation of core clinical processes to presenting problems other than for what they were originally intended

• Family therapy is uniquely positioned for adaptation work
  • Inherently context-dependent
  • Improves the ecology of relationships so families can be more supportive when youth struggle

• Some goals of family therapy are fairly universal across disorders, cultures, and presenting problems; yet, thought is needed when adapting a well-defined, empirically-supported treatment for use with another presenting problem or specific population
Purpose

This symposium will present several ways in which one family therapy model has migrated to families with diverse presenting problems and cultural backgrounds.
Attachment Based Family Therapy

Empirically-supported treatment for adolescents/young adults with depression and/or suicidal ideation and behaviors

Treatment goal to repair relational ruptures between caregiver/child

With secure base, caregiver and adolescent better able to manage outside stressors
ABFT Treatment Tasks

Task I: Relational reframe task
Task II: Adolescent alliance task
Task III: Parent alliance task
Task IV: Repairing attachment task
Task V: Autonomy task
Objectives of Symposium

1) To describe how the clinical tenants of ABFT may be applicable to diverse populations and presenting problems

2) To understand the evidence supporting the adaptability of ABFT

3) To evaluate the treatment modifications developed to adapt ABFT for specific populations, across three different countries
Attachment-Based Family Therapy for Transgender and Gender Diverse Youth

JODY RUSSON, PHD, LMFT
SUZANNE LEVY, PHD
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Suicide and TGD Youth

Suicide is a serious public health problem for youth in the U.S (Hoyert & Xu, 2012)

Sexual and gender minority youth are particularly vulnerable (Perez-Brumer, et al, 2017)
  ◦ Transgender and gender diverse (TGD) youth more vulnerable than sexual minority (Bauer, et al., 2015)

Many TGD youth are healthy, yet 30-50% of TGD youth attempt suicide during adolescence (Toomey, et al., 2018)
  ◦ Suicidality has been linked to internal (i.e. gender dysphoria, internalized transphobia) and external (i.e., caregiver rejection, discrimination) minority stressors (Grossman et al., 2016; Testa et al., 2017).
  ◦ Adolescence can be particularly challenging for TGD youth as they begin to solidify their gender identity
    ◦ Increasing awareness of transphobic discourses presented in their families, peer groups, media, and/or communities may lead to shame and distress (Yüksel et al, 2017).
    ◦ Secondary sex characteristics develop, potentially exacerbating gender dysphoria (Drescher & Byne, 2012; Steensma et al., 2011)
Family Relationships and Suicidality

The World Professional Association for Transgender Health (WPATH) (2012) provides standard of care guidelines when working with TGD youth.

Unfortunately, access to these services is often limited due to professional/familial gatekeeping (Klein & Golub, 2016).

Barriers lead many TGD youth to feel depressed and powerless:
- Youth must rely on intolerant or ambivalent caregivers to make decisions about care (Drescher & Byne, 2012).

Caregiver support protects against suicide risk (Bauer et al, 2015; Mustanski & Liu, 2013; Ryan, 2009).

Criticism, unresponsiveness, rejection may contribute to depression and suicidality (Klein & Golub, 2016).

While many families of TGD youth are supportive, wider social discourses about gender may make TGD youth vulnerable to experiencing rejection and conflict in their families.
Family Treatment Approaches

TGD youth have been absent from suicide treatment research

Impact of caregiver relationships on well-being of sexual and gender minority youth suggests importance of family treatment

- Diamond, G.M, et al., 2013

Even when family factors are not the cause of distress, it may be that many youth do not turn to their caregivers for help with victimization, fearing caregivers will not protect them (Hammelman, 2008)

Limits capacity for caregivers to serve as a resource as their children navigate complex social issues
Implementation Pilot Study: ABFT for TGD youth

Partnered with LGBTQ+ focused organizations in mid-Atlantic city

Formed stakeholder groups to understand barriers, facilitators and recommendations for implementing ABFT with LGBTQ+ organizations

Pilot study for LGBTQ+ youth and their caregivers, using recommendations from stakeholders for delivery modifications

- Primarily TGD youth referred (80% of participants)
- Need for adaptation for TGD youth became evident
- Consultations with ABFT developers and LGBTQ+ affirmative clinicians for continued refinement of adaptations
Preliminary Treatment Adaptations

Pre-task I work (before Task I, Relational Reframe Task)
Respecting Autonomy (in Task I, Relational Reframe Task)
Location of self (in Task II, Youth Alliance Task)
Caregiver Education (in Task III, Caregiver Alliance Task)
Sequencing Ruptures (in Task IV; Attachment Task)
Expanded Parental Disclosure Phase (in Task IV; Attachment Task)
Advocacy Skills (in Task V; Autonomy Task)
Pre-task I Work

Engage family in Task II and Task III processes (pre-task I work) before Task I

Increase the success of Task I

Allows therapist to assess for safety and outness in family

With youth
  ◦ See therapist as a trustworthy provider
  ◦ Opportunity for youth to begin to take ownership of treatment by identifying which caregivers to bring in

With caregivers
  ◦ Soften blame and reduce anxiety
  ◦ Some caregivers worry about being blamed by providers in LGBTQ+ service settings (Russon et al., in preparation)
  ◦ Assess where the caregiver is on the continuum of acceptance and decide course of involvement (Diamond GM et al., 2012)

In some cases, family members of choice are invited

In other circumstances, the therapist does not conduct a Task I and, instead, works individually with youth and caregivers until repair can be facilitated in Task IV
Respecting Autonomy & Location of Self

Respecting Autonomy in Task I
- Many TGD youth have felt a clear lack of autonomy in their lives
- History of requirement to conform to cisnormative “standards” that do not fit
- Therapist ensures that the adolescent feels their autonomy is respected (builds trust)
- Help youth stay engaged in difficult conversations about their relationships while honoring their decision to participate in any therapeutic process

Importance of social location in Task II (Watts-Jones, 2010)
- Intention self-disclosure of therapist identities (e.g., gender, sexual identity, race)
- Unstructured and organic
- Therapist leads
Caregiver Education and Support

_Cisgender_ caregivers of _TGD_ youth often need caregiver education at the beginning of Task III

- Therapist positions themselves as an educator and resource coordinator
- Many supportive caregivers lack knowledge about TGD issues
- Precursor to helping caregivers think through their views and beliefs about their youth’s identity
  - Fear often underlies rejecting behaviors
- Education prepares caregivers to reflect on their own experiences of marginalization and empathize with youth later in Task III (Ibrahim et al., 2018)
  - Particularly for caregivers who have different marginalized identities than their adolescent
Sequencing Ruptures

Content for Task IV may include:
- Identity-specific relational ruptures
- Relational ruptures unrelated to caregiver responses to youth’s gender identity
- Connect both to underlying attachment themes

Therapist helps families sequence Task IV content according to how TGD-specific relational ruptures (e.g., “my mom uses the wrong pronouns”) correspond with attachment themes (e.g., rejection, abandonment).

For those with identity-specific ruptures, therapists must:

1) clarify whether these caused the development of attachment themes and/or exacerbated pre-existing ones

2) Understand when ruptures happened in relation to key milestones in TGD youths’ identity development
Expanded Parental Disclosure Phase

In ABFT, Task IV includes “parental disclosure” phase where caregivers provide context and/or apologize for ruptures (Diamond et al., 2014)

For caregivers of TGD youth, specific types of disclosures are recommended

◦ Caregivers are encouraged to voice how their own biases or cisnormative ideals (e.g. what they assumed was “normal”) might contribute to misunderstandings

◦ Caregivers reflect on how experiences of their TGD youth might be different from their own

◦ TGD youth understand their caregiver’s struggles might be the result of exposure to dominant discourses as opposed to a rejection of them
Advocacy Skills

Teaching caregivers advocacy skills is part of handing back the secure base.

Task V provides an opportunity to address important topics for many TGD youth
- E.g., transitioning, managing stigma, and navigating coming out
- Platform for caregivers and youth to discuss what the youth needs to feel and be authentic
  - For example, transitioning may not be relevant for some youth; instead, the focus may be on working with the school on gender neutral bathroom accessibility

Task V is when caregivers are encouraged to become advocates for their adolescent
(e.g., seeking out affirmative providers, connecting with TGD communities, supporting the youth’s coming out in wider social circles)
Future Directions

Primary finding of implementation study: need for further adaptation of the model for TGD youth

NIMH grant in preparation:
Qualitative interviews with TGD youth and their families

Further treatment adaptation

Randomized efficacy pilot trail of ABFT-TGD for youth at risk for suicide
References


References


Questions

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ATTACHMENT-BASED FAMILY THERAPY FOR KOREAN FAMILIES

Bora Jin, PhD, LMFT
Jody Russon, PhD, LMFT
Suzanne Levy, PhD
Guy Diamond, PhD
ABFT AND KOREAN FAMILIES

• Few evidence-based practices applicable to families with Korean background

• ABFT focus on attachment applicable to families of diverse backgrounds

• However, unique features of Korean parent-child relationships that require consideration (Choi, 2011; Jin, 2015)
The purpose of this paper presentation:

1) To demonstrate how ABFT maps onto theory and traditional values relevant to Korean culture
2) To describe clinical recommendations
CONFUCIANISM

• Confucianism has shaped family relationships in Korea (Kim & Wolpin, 2008)
• Expectation of children to listen to parents
• Parent-child communication is unidirectional rather than collaborative
COLLECTIVISM

• Collectivism pervasive in many relationships in Korean culture
• Collectivism tends to be related to emotion regulation strategies (Trommsdorff, 2015)
• Group harmony prioritized over individual needs/feelings
• Positive emotions are often encouraged or even forced to express
• Impact on emotion regulation capacity
BUJAYUCHIN-SUNGJUNG

- Korean indigenous notion of parent-child bonding includes several distinctive elements such as sacrifice and emotional oneness (Jin, 2015)
- Parents invest significantly in their children
- Many children feel sorry for their parents due to this sacrifice
ABFT ADAPTATIONS

- Adaptations based on ABFT program in Seoul, South Korea
- 40 Families with Korean heritage background
- Adaptation recommendations for each task
- Recommendations connect to Korean values
<table>
<thead>
<tr>
<th>Task</th>
<th>Adaptation Tips</th>
<th>Grounded Theories</th>
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| Task 1 | • Have separate sessions between the parent and the adolescent when needed | • Values in authority (Confucianism)  
• Chemyun (face of the family; Korean indigenous psychology) |
| Task 2 | • Validate difficulties in sharing attachment ruptures  
• Distinguish sharing emotions from blaming others (right for their feelings)  
• Help label their difficult emotions | • Group harmony and Collectivism  
• Filial Piety (Confucianism) |
| Task 3 | • Set up the level of authority that parents feel comfortable to build the trust  
• Be aware of importance of alliance building with mothers  
• Acknowledge their efforts and sacrifice | • Hierarchical culture  
• Values in authority and role of mothers (Confucianism)  
• Parental sacrifice (Korean indigenous notion of parent-child bonding; Bujayuchin-Sungjung) |
| Task 4 | • Assure they don’t have to accept parental apology when they are not like it  
• Rephrasing parents’ comments with attachment-induced language | • Emotional oneness (Korean indigenous notion of parent-child bonding; Bujayuchin-Sungjung)  
• Top-down communication styles (Confucianism) |
| Task 5 | • Individual sessions with adolescents | • Values in obedience and authority (Confucianism) |
TASK I: RELATIONAL REFRAME TASK

• Considerations
  • Values in authority
  • Chemyun

• Possible Challenges and Approaches
  • Korean adolescents often feel responsible to protect their parents.
  • Therapist needs to alleviate this felt responsibility (e.g. validating parental efforts)
  • Many require separate sessions with parent and adolescent when needed
TASK II: ADOLESCENT ALLIANCE TASK

• Considerations
  • Group harmony and Collectivism
  • Filial Piety

• Possible Challenges and Approaches
  • Therapists explore adolescents’ struggles when talking about difficult emotions before understanding the parent-child ruptures
  • Validate difficulties in sharing attachment ruptures
  • Distinguish sharing emotions from blaming others (for their feelings)
  • Help label difficult emotions
A: Thinking back then, it was dad’s fault blaming and cursing me while I was going through a real tough time. He always says you got to be stronger. I don’t like him... Well When I am with him, I am so stressed out. I feel like I will get beaten and criticized. I feel terrified. I have to watch him all the time. I hate him being so authoritarian. It is hard. To be honest, it is really hard. 

...continued

A: One night dad screamed in the middle of the night. I thought he had some anger management issues or so but realized that he could not breathe because of esophagitis. It was regrettable that he did not die.

T: You are that angry at your dad.

A: Yes, I am so resentful of him. Why did he do that to me when I was little. Why did he do that when I was in the middle school.

T: How was he like when you were little.

A: I got hit when he taught me Korean. He was very violent. I blame him.

T: You must be really little when you first learn Korean. How old were you?

A: I was almost 6 (Korean age, The actual age will be 4 or 5)

T: You were really little. But he beat such a little boy? How did you feel?

A: I thought it was okay because it was always like this. But now I am thinking it is not okay. When dad did not feel good, he used to beat me, It is all up to his mood.

Another story, we were watching a wrestling game together. Dad approached me frst to try the wrestling skills to me. So, I also did the same thing in response thinking it is sort of play. I was only 1st or 2nd grader at the elementary school. How could I know whether it is dangerous or not and whether I shouldn’t do it or I am allowed. But, he beat me black and blue... It was just play which he initiated. I am so resentful of him.

Continued...

A: ...I have lots of such memories. It is all up to his mood. It is not different now. He got furious when he is not feeling well.
TASK III: PARENT ALLIANCE TASK

• Considerations
  • Hierarchical culture
  • Values in authority and role of mothers
  • Parental Sacrifice

• Possible Challenges and Approaches
  • Set up the level of authority that parents feel comfortable to build the trust
  • Be aware of importance of alliance building with mothers
  • Acknowledge parents’ efforts and sacrifices
D: I don’t know how to approach MW.
M: I am on a same page. I don’t know how to approach MW although I am trying. MW may have certain ways how he wants us to approach him. I have been doing my way. I should’ve asked MW what he wants and feels. When I make a mistake, I tend to keep going although I know it is a mistake. It makes the situation worse. MW becomes shut down.

Continued…

D: I think MW wants dad who can understand him rather than a strong dad. But, I think it is not right since I wanted to be a dad like a friend when I was little. Dads at my age tend to have the similar thoughts. When I meet friends and talk about kids, we say all the same thing. Didn’t we want to be a different father to our kids? We find we are not living up to our hope. I thought I can an egalitarian father who is like a friend but I found I cannot do it. We did not want to be a father like ours but we found we are not very different from our own. Dads were busy in making money in the past. They don’t have their own life. It is the time when kids need lots of financial support. People say you cannot do anything for yourself. I am actually living like that. I cannot do anything for myself. People say when you become 50s it will be a little better after kids grow up. However, it is also an important part of life but I have been making excuses for my shortcomings.

T: You have been doing great all by yourself, independently.
D: I tried.
T: You’ve got rewarded as much as you put effort on the work so it will be hard for you to try the other way around (such as perspective taking).
TASK IV: ATTACHMENT TASK

• Considerations
  • Bujayuchin-Sungjung: Emotional oneness

• Possible Challenges and Approaches
  • Sessions sometimes begin with the adolescent honoring the sacrifices that parent has made
  • Assure adolescent that they don’t have to accept parental apology
  • Rephrasing parents’ comments with attachment language
A: I think I have start with the most important thing first. I committed suicide. You know there were twice as far as you know. The most difficult thing was what I was struggling most was I had an unfair experience at school. I came home in the middle. If you said just one word, okay nothing would’ve happened. You rather criticized me I felt really tough. You denied what I was going through.

You said ‘I am even in tougher situation. It is not a big deal.’ It is the hardest part for me when you say like that. It feels like my values and feelings are ignored because of what you have gone through, which I even don’t know. Whenever you do that, I feel extremely stressed out and become out of mind. I don’t know what to do when I feel that way.

D: When we went to the Costco...

A: It was really hard for me.

D: You were really in pain. Yes. I think it must be really hard for you. I feel very sorry for the fact that I did not understand you. I should’ve understood you from your perspective. But, I did not do that. I said everything from my perspectives even though you were so struggling. I was only thinking about myself and underestimated your pain. I am so sorry for you. You had your own difficulties but I always put my own standard first. Only me...

T: (Silence for 10 seconds) MW, you can keep going.

A: Okay.. (moved to another topic...)

A: when things get really tough, you know people ask help. However, if they cannot talk about it, they express it to signal their pain to receive help and care. In fact, I write all my pains in my social media but as time goes, no one would pay attention to it. I started self-harm to get the attention I needed. You may not understand but I am doing it for the attention and care. As keeping doing it, it became a coping skill to manage my stress. I think of self-harm often times although I don’t do it anymore. I was trying really hard to live despite the pain but no one would understand me. It was really tough. No one recognized the signals of my pain. It was really tough for me.

D: You have asked for the help really hard from mom and dad...

M: You send the signals but mom and dad did not see your pain but rather scolded you for doing it. You then got no one to talk to and rely on. I feel sorry thinking you were all alone. I would like to be a person who you can talk to and think together about alternatives. I am sorry, MW, for the fact that I scolded you without paying attention to the background. I am also sorry I never said sorry to you. I am sorry MW and I love you. I hope I can be the person you can trust and rely on.

A: I think I am like emotionless. Actually rather than emotionless, it feels bothersome to feel the emotions. I am neither happy nor sad for anything, no tears no smiles I just live without emotions. Rather, I feel so tired of feeling emotions. I hate myself for becoming like this.

M: It is okay. People don’t express all the emotions they have but it is you who express slowly. We can help if you want to change but I hope you are not stressed out too much for not being able to control your emotions.

A: I am...

M: It’s okay. It’s okay.

A: Every night, the events that happened in the middle school comes up to my mind. Every time before going to bed. It keeps coming up so I cannot sleep well. I also so worried about what happened during the day time at school. Thinking back if friends will hate me or talk behind my back. I am always worried. I am very stressed out just being around people. I am afraid of waking up in the morning. So, every night it is really tough. I cannot fall asleep because of those thoughts and worries.
TASK V: AUTONOMY PROMOTING TASK

• Considerations
  • Values in obedience and authority

• Possible Challenges and Approaches
  • Some individual sessions with adolescent
  • Allows parents to practice trusting the autonomy of their adolescent
REFERENCES


THANK YOU
ANY QUESTIONS?
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Adapting Attachment Based Family Therapy for Young People with Eating Disorders

Julian Baudinet, Keren Smith, Helen Wilde, Dianne Russell & MCCAED Team
Family Therapy for Adolescent Eating Disorders (FT-ED): Brief Description

- Outpatient treatment
- Family Therapy is first line recommended for both anorexia and bulimia nervosa (NICE, 2017)
- Typically a 6-12 month treatment
- Manualised
- Evidence based
- Similar (but not same) approach for anorexia and bulimia
**FT-ED: Phases**

- **Phase 1:** Engagement and development of therapeutic alliance
- **Phase 2:** Eating disorder symptom management
- **Phase 3:** Exploring issues of individual and family development
- **Phase 4:** Ending and discussion of future plans
**FT-ED: Outcomes**

**Anorexia Nervosa (FT-AN)**
- Full remission by the end of treatment for AN between 35-50% (Lock, 2015)
- 10-40% have a poor outcome (le Grange, 2014; Lock, 2015)

**Bulimia Nervosa (FT-BN)**
- Only 35-45% full remission of symptoms at the end of treatment and follow up (le Grange, et al., 2007; 2015; Schmidt, et al., 2007)
Certain family factors impact outcome

Predictors of poorer outcome:

- High expressed emotion
- Family conflict
- Criticism
- Inpatient admission
- Severe OCD
- Co-morbidity

Gap Identified
Phase 1: Engagement

Phase 2: Symptom management

Phase 3: Individual and family development

Phase 4: Ending

Stuck points

Start of treatment

Moving to independence / individuation

Relapse
Assumption of the model:

Parental support is interpreted as care

Which is certainly not the case for all ...
We also noticed ... 

Things vary a lot depending on diagnosis
Eating Disorders, Attachment & Relationships

**Bulimia Nervosa**
- High criticism & hostility reported

**Anorexia Nervosa**
- High suppression of emotional expression

Higher general eating disorder psychopathology associated with more insecure attachment regardless of diagnosis (Tasca & Balfour, 2014)
Physical Health & Risk
- Medical and psychiatric risk to manage
- Physical impact of ED symptoms

Treatment Targets
- Eating disorder, relationship difficulties or both?

Temperament
- Distinct temperament, personality and coping profiles of different eating disorders
Adaptation 1
Language

- Very similar to standard ABFT but we switch suicide language with eating disorder symptom language as needed

"when your daughter is all alone and starving herself/making herself sick what gets in the way of her coming to you for help"
Adaptation 2
Physical risk: contracting

- During Task I families are contracted to manage food and eating with only minimal therapist input for duration of Tasks II-IV

- Weight does not need to be within healthy range nor binge-purge behaviours ceased – just need to contract medical risk won’t escalate

- Sign on can be particularly hard for young people with AN due to restricted affect and overly agreeable presentation
Adaptation 2
Physical risk: ED symptom escalation

- Pause ABFT as contracted and briefly switch to symptom focus
- Return to management plan, skills and contract
- Continue using attachment lens and language when managing brief pause.
- We consider day programme treatment if escalation continues where parallel ABFT and FT-ED can occur
Adaptation 3
Task II & III: Psychoeducation & Skill Building

**Bulimia Nervosa**
- Psychoeducation about temperament, personality and BN maintenance factors
- Focus on core maintenance factors of BN (shame, guilt, self-esteem, blame etc)

**Anorexia Nervosa**
- Psychoeducation about temperament, threat sensitivity, impacts of starvation, emotional suppression & loneliness
- Build skills to enhance emotional expression
Adaptation 4
Task IV: Biological & Temperamental Sensitivity

- Need to be mindful of impact of starvation and temperament during the task.
- Emotion coaching around core ED symptoms: fear of weight gain, shame, guilt often needed
- **Anorexia**: Often characterized by supporting young person to use skills to become more genuine in emotional expression & entitled to attachment needs.
- **Bulimia**: Typical focused on shame, guilt, criticism and blame.
Adaptation 5
Task V: Symptom Focus & Return to FT-ED

- Collaborative symptom management needs to be negotiated
- This needs to precedes independence and developmentally appropriate individuation
- Ongoing parental emotion coaching around body dissatisfaction / fear of weight gain often needed
- May need to return at this point to FT-ED
Data currently being collected (case series and qualitative interviews)

Feedback from clinicians and families suggests it is very helpful – particularly conversations about intentions and meaning of behaviours.

Very helpful for parents who are struggling with rationalising disorder/body image concerns. Helps them to speak to underlying emotion rather than get caught in cyclical, unhelpful discussions about their child not being ‘fat’

Especially useful for young people with bulimia / emotionally dysregulated presentation

Watch this space …
Questions & Feedback

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