Adapting Attachment-Based Family Therapy for Depressed and Suicidal Gay, Lesbian, and Bisexual Adolescents

Being Gay and Adolescent

Adolescence is both an exciting and challenging time. It is a period of rapid cognitive, emotional, and physical growth, coupled with increasing autonomy. As a result, adolescents are exposed to many new experiences which, ultimately, help shape their definition of self and way of relating in the world.

For most of the approximately 5% -10% of youth who are gay, lesbian, or bisexual (GLB), or who are questioning their sexual orientation, life is more complicated than for their heterosexual peers. These teenagers face not only the normal developmental challenges of adolescence (e.g., identity formation, romantic relationships), but also face additional stressors commonly associated with being a sexual minority, including confusion, shame (i.e., internalized homophobia), fear, rejection by family and peers, and abuse/victimization.

Depression and Suicidality

While the majority of GLB youth are healthy, resilient, and well functioning[7] many end up depressed or even suicidal. A host of cross-sectional studies have found that GLB youth have higher rates of depression, hopelessness, suicidal ideation, and suicide attempts than their heterosexual counterparts. In fact, GLB youth are twice as likely as heterosexual youth to experience suicidal ideation or to report making a suicide attempt.[6] Obviously, there is nothing inherently suicidal about a lesbian, gay, or bisexual orientation. Instead, it is most likely that environmental responses such as discrimination, victimization, and rejection contribute to self-loathing and depression which in turn leads to suicidal ideation and behavior.[6,7]

Family Relationships

One important suicide risk and protective factor is the quality of the adolescent-parent relationship(s). A substantial amount of research, including both prospective and cross-sectional studies of both community and clinical samples, has linked parental criticism, emotional unresponsiveness, rejection, control, and lack of care and support to adolescent suicidal ideation and attempts.[8] Unfortunately, GLB adolescents may be particularly at-risk for conflict with parents, parental criticism, and parental rejection. Because of pervasive societal homophobic messages, some parents may, at least initially, perceive their child's same-sex orientation as unnatural, perverse, immoral, and/or dangerous. Such perceptions can lead to parental feelings such as disappointment, loss, shame, guilt, anger, disgust, and/or embarrassment which, in turn, can produce a range of behaviors, including denial, disapproval, rejection, threats, humiliation, abuse, violence, and ejection of the adolescent from the home.[7] When parents reject, disengage from, invalidate, or otherwise express discomfort with their adolescent's sexual orientation, the message conveyed is that something is wrong with the adolescent. Such a message, delivered from the most important people in the adolescent's life, can exacerbate self-loathing, depression, and hopelessness—all correlates of suicide. Results from a survey of GLB youth in the greater New York City area showed that a history of parental psychological abuse differentiated between those youth who had made a suicide attempt versus those who had not.[3]

In the same way that family conflict, rejection, and other negative processes are associated with greater suicidality, family cohesion appears to protect young people. GLB adolescents who report high levels of parental support and good communication with parents report fewer mental health symptoms and less suicidal ideation and attempts.[3] After controlling for other factors, such as depression and stressful life events, those adolescents describing their families as mutually involved and demonstrating a high degree of shared interests and emotional support were 3-5 times less likely to be suicidal than their peers from less integrated families.[5] When parents accept their adolescent's sexual orientation as an integral and valued aspect of their child, they validate their child and are positioned to support, guide, and advocate for him/her

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as he/she negotiates the challenges of growing up with a minority sexual orientation. Research findings suggest that a strong adolescent-parent relationship can buffer against the effects of gay-related victimization occurring outside of the family.[2]

Treatment

Despite their high-risk status, to date there has been very little written on the development and testing of treatment models for suicidal and depressed GLB youth. The American Psychological Association (APA) has developed Guidelines for Psychotherapy with Lesbian, Gay, and Bisexual Clients. These guidelines emphasize the importance of understanding that homosexuality is not a mental illness and educating therapists to recognize their own potential biases. Therapists must understand and take into account issues and challenges that exist for GLB clients such as: rejection, discrimination, and harassment due to GLB status; internalized homophobia; and shame. In addition, therapists must understand the relationship between these challenges and psychological symptoms such as anxiety and depression; the process of "coming out" and its impact on work, peer and family relations; and the benefits of being GLB, including the community and social support groups available to these clients.[1] While these guidelines provide a necessary and essential frame of reference for work with GLB clients, more work is needed to systematically integrate these themes and processes into coherent, well-articulated models for working with specific sexual minority populations. Such models should include defined targets of treatment, purported change-mechanisms, and specified intervention strategies.

A Promising Approach

One promising treatment model for working with depressed and suicidal GLB youth is Attachment-Based Family Therapy (ABFT). ABFT is promising for three reasons. First, it is a manualized, empirically-based family treatment specifically designed to ameliorate depression and suicidal ideation among adolescents. Second, its primary aim is to improve the quality of the adolescent-parent attachment relationship (i.e., reduce conflict and criticism and increase care, support and warmth)a risk/protective factor robustly associated with adolescent suicidality in general, and suicidality among GLB youth in particular. Third, there is preliminary data regarding the efficacy of the treatment. In a pilot randomized clinical trial comparing 12 weeks of ABFT to a wait-list control condition, 81% of ABFT cases no longer met criteria for Major Depressive Disorder post-treatment, compared to 47% of the control group. In addition, among ABFT cases, average scores on the

Suicidal Ideation Questionnaire decreased from 34 pre-treatment to 21.[4] Importantly, data suggests that up to one third of these clients were of minority sexual orientation.

The first half of ABFT focuses on improving the quality of the adolescent-parent attachment relationship. Once the attachment bond has been repaired, the second half of treatment focuses on promoting adolescent autonomy and pro-social functioning outside the family. The five treatment tasks of ABFT have been designed to meet these goals.

The first task, the relational reframe, aims to shift the focus of the therapy away from parents ascribing negative or critical characteristics to the adolescent (i.e., "stubborn," "manipulative") which fuel adolescent anger and withdrawal, and onto the events/processes which have ruptured or diminished the quality of the adolescent-parent relationship, and reduced the possibility of the adolescent turning to the parent for support. Such shifts are accomplished through relational reframe interventions. For example, a therapist might ask the adolescent, "Why don't you turn to your mother when you feel so bad that you want to die?"

Once the relational frame has been established, the therapist meets with the adolescent and parent separately to build alliances. In meetings with the adolescent, the therapist builds trust and learns more about the adolescent's interests, concerns and aspirations. These sessions are also used to identify core family dynamics that fuel conflict, and to prepare the adolescent to discuss such issues with her/his parent(s).

Alliance-building with the parent focuses on reducing parental distress and improving parenting practices. The therapist shows interest in the parent as a person, expressing care and acknowledgment of the parent's strengths and accomplishments. Next, the therapist supportively explores stressors currently affecting the parent (e.g., marital problems, financial difficulties, traumatic childhood history, psychiatric distress). When parents experience empathy for their own vulnerabilities, they become more empathic regarding their adolescents' struggles. In this softened state, parents recognize the importance of providing support and care for their teenagers, and are more receptive to learning parenting skills that focus on affective attunement and emotional facilitation.

Once alliances with the adolescent and parent(s) have been established, and the adolescent and parent are prepared, reattachment begins. Reattachment episodes are designed to facilitate conversations between adolescents and their parents about past/current relational ruptures. The episodes begin with the adolescent disclosing her/his vulnerability associated with past and present events that have violated the attachment bond and damaged trust. As parents respond empathetically, adolescents are more forthcoming. During these conversations, parents often take some responsibility for attachment failures which, in turn, promotes forgiveness on the part of the adolescent and renews mutual interest in repairing the relationship. This task diffuses family tension and increases the like-

lihood that a suicidal adolescent will seek support from a parent.

Once tensions between the adolescent and her/his parents have lessened, the parents are in a better position to encourage, guide, and support their adolescent in developing autonomy. This fifth task of ABFT, promoting competency, is designed to help parents help their adolescent improve school functioning, successfully navigate peer relations, participate in social activities, and so on. Success in such domains contributes to the adolescent's sense of efficacy, which can buffer against further hopelessness, depression, and suicidal ideation.

Current Project

While ABFT has shown some promise with depressed and suicidal adolescents in general, more work is necessary to insure that the approach addresses the unique content domains and individual, family, and contextual processes and developmental tasks of GLB youth. Thus, a treatment development team at the Center for Family Intervention Science, Children's Hospital of Philadelphia, is working to develop and test a GLB-sensitive version of ABFT for suicidal and depressed GLB adolescents.

This project is planned to span three years and includes two stages. Stage one is to adapt the current ABFT manual to include the specific content, tasks, and therapeutic strategies required to make treatment relevant, acceptable, and feasible for treating GLB suicidal and depressed adolescents and their families. The members of the treatment development team will utilize their clinical experience, results from qualitative interviews, observations from archived videotaped sessions of ABFT delivered to GLB suicidal adolescents, and the extant empirical and clinical literature on treating GLB youth in order to revise the treatment model.

Stage two involves conducting a pilot randomized clinical trial comparing 12 weeks of ABFT-GLB to 12 weeks of Enhanced-Usual-Care for suicidal and depressed GLB adolescents. The purpose of this stage is to examine the treatments' acceptability to therapists, adolescents, and parents; therapist adherence to the model; the characteristics of the outcome and process measures over time; and the relative impact of the two treatments on suicidal ideation, depressive symptoms, family functioning, and internalized homophobia.

Conclusion

This project represents one attempt to develop and test a treatment model for a specific sub-group of GLB adolescents – those suffering from depression and/or suicidal ideation. However, what about those adolescents whose families are not willing or able to participate in the treatment process, or adolescents who don't want their families involved? What about GLB adolescents with co-morbid drug abuse or who suffer from severe anxiety disorders? Such adolescents would clearly need a modified or different approach. Thus, the challenge remains. Much more work is needed to translate the spirit of the APA Guidelines for Psychotherapy with Lesbian, Gay and Bisexual Clients into practice.

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