Letter from the Chair

Defined as a feeling that something desirable is likely to happen, hope undergirds the ability to move forward. The social work profession celebrates the resiliency and strength of those we serve. In July 2012, NASW hosted a national conference titled, “Restoring Hope: The Power of Social Work.” This conference was dedicated to the capacity-building ability of our profession. In keeping with this theme, this newsletter highlights hope.

Jonathan B. Singer, PhD, LCSW, a professor at the School of Social Work at Temple University, offers hope for suicidal adolescents and their families. Dr. Singer speaks to the heart of most families’ tragedies. In his article, he presents an overview of attachment-based family therapy (ABFT), which is a family therapy approach centered on the parent-child relationship. He provides an overview of ABFT and presents strategies for exploring and fostering the parent-child relationship. His article challenges our thoughts on other treatment frameworks.

Dr. Jack Monell, ACSW, Mr. Fred Barnes, LGSW, and Dr. Charisse Coston combine their collective experiences and knowledge to provide an overview of hope for adjudicated youth and their families. The authors explore the main challenge of working with this population: a sense of hopelessness. Through their discussion of multisystemic therapeutic approaches, the authors provide insight into building empathy skills within the offender and their families.

As Specialty Practice Section members, you are demonstrating hope for your practice by seeking to expand your knowledge in your discipline. The CAYA Committee is dedicated to meeting your professional needs and expectations, and encourages you to give feedback about this newsletter as well as to suggest topics for future issues. Together, we are the power of social work.

We look forward to hearing from you.

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Chair, Children, Adolescents, and Young Adults Specialty Practice Section
On the evening of March 9, 2012, Eden Wormer, an eighth-grade student in Vancouver, Washington, gave her father a hug and a kiss and said, “I love you daddy, goodnight” (Sinmaz, 2012). The next morning, she was found dead in her room; she had hanged herself. Somewhere between the hug and kiss, and the morning light, Eden decided the best way to solve her problems—being victimized by bullies, feeling ostracized and misunderstood—was to kill herself.

The tragedy of Eden Wormer’s suicide is compounded by a grim statistic: by the end of 2012, more than 1,800 young adults in the United States will die by suicide, making it the third leading cause of death among youth ages 5 to 19. For each child who commits suicide, there are hundreds of thousands more who are at risk. In 2011, 15.8 percent of high school students reported seriously considering suicide, 12.8 percent reported making a suicide plan, 7.8 percent attempted suicide, and 2.4 percent reported receiving treatment from a doctor or nurse as a result of their suicide attempt (Eaton et al., 2012). One of the most disturbing aspects of these statistics is that they represent the first increase in youth suicidal ideation, planning, and attempts since 1995, reversing a 15-year downward trend. Although social workers are expected to provide crisis intervention services, including suicide assessment and intervention (CSWE, 2009), they receive very little training in the treatment and management of suicidal behaviors (Feldman & Freedenthal, 2006). Therefore, this article will provide a brief overview of an empirically supported approach to working with suicidal youth and their families—attachment-based family therapy (ABFT) (Diamond et al., 2010).

OVERVIEW OF ABFT
ABFT is a trust-based, emotion-focused psychotherapy model that aims to repair interpersonal ruptures and rebuild an emotionally protective, secure parent–child relationship (Diamond et al., 2001). ABFT restores a young person’s hope
that he or she can have a life worth living, and it reestablishes the family as a source of strength and support during suicidal and other crises (Levy et al., in press). Hope is instilled via five tasks over the course of 12 to 16 weeks. Therapy includes conjoint family sessions and individual sessions with the adolescent and the parents. ABFT has an emerging evidence base for use with a range of youth, including those who have a history of trauma, depression, and anxiety; those who identify as lesbian, gay, or bisexual; and those who have been evaluated primarily with low-income, multiproblem urban families (Diamond et al., 2001, 2010).

ABFT’s approach to addressing suicidal youth differs from traditional cognitive behavioral treatment in three ways: 1) ABFT is grounded in attachment theory; 2) clinicians rely heavily on emotion-focused techniques rather than cognitive or behavioral techniques; and 3) the model addresses youth suicidal behavior by repairing or strengthening the family system, specifically the parent–child subsystem, not the individual. Because like all manualized treatments, ABFT has been extensively documented, rather than providing a review of the model, the rest of this article presents three treatment tasks central to ABFT’s success that can be incorporated into clinical practice.

**REFRAME YOUTH SUICIDAL BEHAVIOR AS A FAMILY-SYSTEMS ISSUE**

ABFT provides clinicians with a family-systems perspective on suicidal behavior among youth. Rather than focusing on an individual’s thoughts and the core beliefs associated with the suicidal ideation (e.g., “I am worthless,” “I am unlovable,” or “life is unfair”), ABFT focuses on the quality of the relationship between the parent(s) and child, and it assumes that reducing parent–child conflict and improving perceived support will diminish suicidal risk. Research has found that suicidal youth have more conflictive, less supportive relationships with their parents than do non-suicidal youth (Wagner, 2009). One implication of this study is that suicidal behaviors are understood to be efforts by the youth to bring their parents back into their lives. The first task of ABFT, therefore, is to reframe the child’s suicidal behavior as a family-systems issue. Specifically, clinicians work on getting families to agree that the solution to the child’s suicidal behavior lies in repairing or strengthening the parent–child relationship. Finding the solution within the family to deal with the child’s suicidal behavior provides hope for the parents, who often feel like failures, and the youth, who often feel alone in the face of overwhelming pain. ABFT presents parents with an opportunity to be successful at their essential and nurturing caregiver functions. ABFT provides youth with an experience of their parents as allies to help them to restore their will to live.

**EXPLORE THE PARENT–CHILD RELATIONSHIP**

Unlike many family therapy approaches, including traditional models like structural family therapy or contemporary models like functional family therapy, ABFT believes that exploring the parent–child relationship in individual sessions is beneficial.

In the individual sessions with the child, ABFT addresses the question, “When you are thinking of killing yourself, what keeps you from going to your parents?” The social worker looks for descriptions of such attachment ruptures as abandonment, rejection, betrayal, injury, or violation. Examples of attachment ruptures include, “I’d love to go to my mom, but every time I do she tells me to quit bothering her / tells my dad / gets mad at me / threatens me.” Alternately, a youth might say, “I’d never go to my dad because he has never been there for me.” On the surface it seems counterintuitive to instill hope by digging up a child’s pain and loss. Indeed, postmodern treatments such as solution-focused therapy and narrative therapy would argue that such a conversation would reinforce, rather than resolve, a problem-focused narrative. But ABFT assumes that for suicidal youth, identifying and exploring the emotions associated with an attachment rupture are essential for repairing and strengthening the parent–child relationship. The social worker can then explore and validate the youth’s desire for a more supportive and loving relationship with his or her parent(s).

When social workers talk with parents about suicidal youth, they often find parents who are shocked by the extent of the crisis, are in denial about it, or are just plain lost about the next steps. In the individual session with the parent(s), ABFT explores the factors that might prevent parents from having a warm and supportive relationship with their teen. These often include stressors associated with work and personal relationships, and what the parents’ relationship was like with their own parent(s). The social worker can then explore the parents’ sense of loss at not having the desired relationship with their child. “I know it might seem hopeless right now, and you might feel like giving up, but your child needs you now more than ever.” Exploring this content offers social workers powerful insight into how willing and able parents are to be supportive of their suicidal child.

**ORCHESTRATE AN EXPERIENCE OF HOPE**

Attachment theory suggests we create mental models of our relationships at an early age. ABFT assumes these models are flexible and can be changed through conversation rather than through behavioral control. For example, a youth with “abandonment issues” might have a mental model of his or her parent as someone who cannot handle intense emotions and is therefore constantly leaving him or her when things get rough. This mental model of an intimate relationship will follow the adolescent into his or her adult relationships unless he or she has a different and better experience of his or her parent. ABFT sets up a conversation (or in family therapy language, an “enactment”) in which the child is able to fully express his or her attachment-related feelings and needs in a direct and regulated manner, and the parent responds with care, respect, and authenticity. As a result, the youth has a new experience of his or her parent, which changes his or her mental model of how this
parent will respond to his or her needs. In the language of attachment theory, this conversation enables the family to have an experience of secure attachment. 

**CONCLUSION**

ABFT provides a framework for addressing youth suicidal behavior within a family context. Three tasks social workers can incorporate into their practice include 1) reframing the problem from an individual problem to a family problem, 2) exploring the parent–child relationship in individual sessions, and 3) orchestrating conversations between the child and parent(s) about the things that keep them from approaching one another. The ultimate goal of ABFT is to reduce depressive symptoms and suicidal risk by improving the quality of the parent–child relationship. Successful treatment in ABFT includes diminished suicidal ideation and depressive symptoms, willingness by the teenager to go to his or her parents when things are bad, and parents’ ability to support and validate the youth. Social workers who use emotion-focused techniques, who have training in psychodynamic and attachment therapies, or who take a family-systems approach to treatment will find ABFT’s method to working with suicidal youth a welcome alternative to the dominant cognitive behavioral approaches.

**REFERENCES**


SENSE OF HOPELESSNESS

In working with adjudicated youth within the criminal justice system, you often find—in addition to all of the disadvantages or challenges they may face in integrating back into society—one of the biggest barriers is their self-inflicted sense of hopelessness. Among the adolescents who are most involved in the juvenile justice system is an overrepresentation of youths who are minorities and/or who are from lower-income families or impoverished communities. As cited by Peters (2011), “the correctional system affects individuals and communities at the heart of social work’s effort: people who are poor and people of color” (p. 355).

As social workers continue to constitute the majority of mental health practitioners in criminal justice, their role is vital in addressing the adolescent population because one of the many issues these clients face is the loss of hope. According to Te Riele (2010), the philosophy of hope has been a concept or theoretical framework utilized throughout various youth studies and education. In clinical settings, what you often find is client desperation, especially among young people who have been adjudicated through the juvenile justice system. Continued research indicates that young offenders are entering the system dually diagnosed with a mental illness and substance abuse, and are living in poverty (Peters, 2011).

SOCIAL WORK STRATEGIES

For the social worker, one of the initial steps is trying to gauge the level of hopelessness that exists within the youth and his or her family. Constant defeats, disappointments, setbacks, and other life events can wear down the most optimistic individuals and families. Utilizing a strengths-based perspective is vital to instilling hope in adjudicated youths, and that particular approach will help to reframe some of those disappointments and defeats that are detrimental to progress. In African American families, such practices have become more popular in the social worker–client relationship. In looking at the Afrocentric Intergenerational Practice model, which emphasizes the strengths-based approach, the social worker highlights the strengths in all family members (intergenerational) present in the treatment process (Waites, 2009). This holistic approach is critical in reassuring the initial client, the adolescent, that his or her future is not grim. It further communicates that the entire family is vested in the success and reintegration of the juvenile back into society.

As the social worker begins assessing the strengths of the client and their family systems, he or she also should be thinking of how to frame the information gathered. So often, children and adolescents are told to do their best, and their progress is evaluated through grades, reports cards, and so forth. Because much of the focus is placed on academic performance, or lack thereof, adjudicated youth and their families find school interventions intrusive because of (at times) the neglect of clinically associated problems. These areas of continued concern within juveniles and families are a primary rationale for interventions that address the entire family, not just the adjudicated youth.

In looking at multisystemic therapeutic (MST) approaches, the social worker focuses on intensive family- and home-based intervention approaches geared toward antisocial youth (Tighe et al., 2012). Multisystemic interventions continue to be a preferred method of treatment for at-risk or adjudicated youth. Both clinicians and clients alike find this approach to be one that addresses various functioning within not only the adolescent but also the entire family. Tighe et al. (2012) highlighted the following in their study of adolescents and their families:

Although outcomes were often mixed, families were generally very positive about their experience of MST, in large part due to how they perceived the therapeutic relationship and model of working. The themes incorporate both parents’ and young people’s views, reflecting their broadly similar accounts, both within pairs and across families (p. 3).
CONCLUSION
Instilling hope should be a major objective for any social worker charged with providing services to an adolescent, but we must also recognize that such a task requires time, patience, strong case-management skills, and, finally, clinical interventions, when appropriate. Though one may view hope as a simple concept we all possess, for those under duress—or battling with dysfunction—achieving hope is seen as unattainable.

Although clients suffer from various social, environmental, economic, and emotional dysfunctions, social workers must work to address clients’ lack of self-confidence and inability to cope. In psychological disciplines, Kiselica & Englar-Carlson (2010) discuss how “over the past several years, there has been an increased interest in positive psychology, which emphasizes the fostering of well-being and resiliency in people” (p. 277).

Finally, a key strategy that continues to be employed in reinstilling hope to adolescents and adults is the practice of mediation between offender and victim. This process brings together the victim and offender to speak in a forum that is conducive for both of them: they can articulate their feelings and express remorse or forgiveness. The method assists the victim and offender in gaining a different perspective on the situation and changing their personal views of themselves. Such practices have shown to have positive results among juvenile and adult offenders. According to Flash (2003), mediation can constructively affect a delinquent who uses the experience to show empathy toward victims; it is hoped that the process will positively influence him or her and reduce any willingness to re-offend. For some adolescents, being delinquent is intrinsic. Social workers can challenge that cognitive ideology to include the interventions discussed, among others, and provide adolescents and their families with a sense of hope.

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REFERENCES

Kiselica, M.S., & Englar-Carlson, M. (2010). Identifying, affirming, and building upon male strengths: The positive psychology/


Did You Know?

Social workers who work with juveniles are positioned to recognize the signs of post-traumatic stress and pre-delinquent behaviors. As a result, the profession plays a role in preventing children’s progression in the juvenile justice system during adolescence.

NASW invites current social work practitioners to submit brief articles for our specialty practice publications. Topics must be relevant to one or more of the following specialized areas:

- Administration/Supervision
- Aging
- Alcohol, Tobacco, and Other Drugs
- Child Welfare
- Children, Adolescents, and Young Adults
- Health
- Mental Health
- Private Practice
- School Social Work
- Social and Economic Justice & Peace
- Social Work and the Courts

For submission details and author guidelines, go to SocialWorkers.org/Sections. If you need more information, email sections@naswdc.org.

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