### GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Treatment Description</th>
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<tbody>
<tr>
<td><strong>Acronym</strong> <em>(abbreviation) for intervention:</em> RRFT</td>
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<tr>
<td><strong>Average length/number of sessions:</strong> component based, 60-90 minute sessions/ 16-20 sessions (dependent on symptom level of youth)</td>
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<tr>
<td><strong>Aspects of culture or group experiences that are addressed</strong> <em>(e.g., faith/spiritual component, transportation barriers):</em> RRFT is individualized to the needs, strengths, developmental factors, and cultural background of each adolescent and family. This tailored approach is incorporated throughout all components of treatment.</td>
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<tr>
<td><strong>Trauma type</strong> <em>(primary):</em> childhood sexual abuse/sexual assault (with 70% of these youth endorsing other forms of trauma as well)</td>
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<tr>
<td><strong>Trauma type</strong> <em>(secondary):</em> The RRFT model has been evaluated with youth who have experienced physical abuse and assault, exposure to domestic violence, and community violence, as well as child sexual abuse as noted above.</td>
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<tr>
<td><strong>Additional descriptors</strong> <em>(not included above):</em> RRFT is an integrative approach to addressing the heterogeneous symptoms experienced by trauma-exposed adolescents. This population is at high risk for development of PTSD and other trauma-related mental health problems, substance abuse, and revictimization. RRFT targets a broad range of trauma-related psychopathology <em>(e.g., PTSD, depression)</em> and risk behaviors <em>(substance use/abuse, risky sexual behavior, non-suicidal self-injury (NSSI)).</em> This risk reduction treatment is novel in its integration of these components, given that standard care for trauma-exposed youth often entails treatment of substance use problems separate from treatment of other trauma-related psychopathology.</td>
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<tr>
<th>Target Population</th>
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<tbody>
<tr>
<td><strong>Age range:</strong> 13 to 18</td>
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<tr>
<td><strong>Gender:</strong> ☐ Males ☐ Females ☒ Both</td>
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<tr>
<td><strong>Ethnic/Racial Group</strong> <em>(include acculturation level/immigration/refugee history—e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans):</em> RRFT is not designed for any one specific ethnic/racial group.</td>
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<tr>
<td><strong>Other cultural characteristics</strong> <em>(e.g., SES, religion):</em> No other characteristics are specifically targeted.</td>
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<td><strong>Language(s):</strong> English-speaking</td>
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<td><strong>Region</strong> <em>(e.g., rural, urban):</em> Rural and urban populations</td>
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<tr>
<td><strong>Other characteristics</strong> <em>(not included above):</em> history of sexual assault/abuse; current or recent <em>(e.g., past 90 days)</em> substance use and/or presence of empirically-identified risk factors for substance use problems <em>(e.g., substance-using peer group, low parental monitoring)</em></td>
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## RRFT: Risk Reduction through Family Therapy

### Essential Components

**Theoretical basis:** Ecological Systems Theory (Bronfenbrenner), Mowrer’s Two-Factor Theory, exposure therapy, cognitive-behavioral therapy, and negative reinforcement theory

**Key components:**
- Psychoeducation
- Coping
- Family Communication
- Substance Abuse - Early Intervention /Substance Abuse – Treatment
- PTSD
- Healthy Dating and Sexual Decision Making
- Sexual Revictimization Risk Reduction

### Clinical & Anecdotal Evidence

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Uncertain</th>
</tr>
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<tbody>
<tr>
<td>Are you aware of any suggestion/evidence that this treatment may be harmful?</td>
<td>☑</td>
<td>☑</td>
<td>☑</td>
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<tr>
<td>Extent to which cultural issues have been described in writings about this intervention (scale of 1-5 where 1=not at all to 5=all the time).</td>
<td>3</td>
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This intervention is being used on the basis of anecdotes and personal communications only (no writings) that suggest its value with this group.

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<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<td>☑</td>
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Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)?

If YES, please include citation(s) from last five presentations:


Danielson, C. K. & Begle, A. M. (June, 2009). *Risk Reduction through Family Therapy (RRFT)*. Advanced Training Pre-Meeting Institute at the annual colloquium of APSAC, Atlanta, GA.
### General Information

**Clinical & Anecdotal Evidence continued**


**Are there any general writings which describe the components of the intervention or how to administer it?**  
Yes  

**If YES, please include citation:**


**Has the intervention been replicated anywhere?**  
No

**Other countries? (please list)**  
N/A

**Other clinical and/or anecdotal evidence (not included above):**  
N/A

### Research Evidence

<table>
<thead>
<tr>
<th>Pilot Trials/Feasibility Trials (w/o control groups)</th>
<th>Sample Size (N) and Breakdown (by gender, ethnicity, other cultural factors)</th>
<th>Citation</th>
</tr>
</thead>
</table>
### General Information

**RRFT: Risk Reduction through Family Therapy**

#### Randomized Controlled Trials

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<tbody>
<tr>
<td>a.</td>
<td><strong>N=30</strong></td>
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<tr>
<td></td>
<td><strong>By gender:</strong> 3 males, 27 females</td>
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<tr>
<td></td>
<td><strong>By ethnicity:</strong> 15 African American, 10 Caucasian, 2 Bi-racial, 2 Hispanic, 1 Native American</td>
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<tr>
<td>b.</td>
<td>Ongoing 2012-2017 RCT</td>
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#### Outcomes

**What assessments or measures are used as part of the intervention or for research purposes, if any?**

- Chart Review of Information from Intake Interview for Trauma; Timeline Followback (TLFB); Urine Drug Screen; Computerized Diagnostic Interview Schedule for Children (CDISC); Family Environment Scale (FES); Alabama Parenting Questionnaire (APQ) – child and parent versions; Children’s Attributional Style Questionnaire (CASQ); K-UPPS Impulsive Behavior Scale; Parent Happiness with Youth Scale/Youth Happiness with Parent Scale; Hopelessness Scale; Emotion Regulation Questionnaire (ERQ); Drinking Motives Questionnaire (DMQ); UCLA-PTSD Index for DSM-IV; Child Depression Inventory (CDI); Behavioral Assessment System for Children (BASC) Internalizing and Externalizing scales; Sexual Risk Behavior Scale; RRFT Fidelity Checklist; Client Satisfaction Questionnaire

**If research studies have been conducted, what were the outcomes?**


- From pre- to post- treatment, RRFT significantly outperformed TAU (p < .05) in:
  - Reducing substance use
  - Reducing specific substance abuse risk factors
  - Improving family functioning (decreasing family conflict and increasing cohesion)
  - Decreasing adolescent PTSD (reported by the parent)
  - Decreasing depression and BASC internalizing symptoms
  - RRFT and TAU showed similar reductions in adolescent-reported PTSD and BASC Externalizing scales.
  - There were no outcomes on which TAU significantly outperformed RRFT.
| Implementation Requirements & Readiness | Space, materials or equipment requirements?  
Treatment sessions can be conducted office-based or in the community.  
Supervision requirements *(e.g., review of taped sessions)*?  
In-person training by an RRFT trainer and aid in implementation with an RRFT consultant. Trained RRFT supervisors review RRFT supervision forms completed by therapists prior to supervision.  
To ensure successful implementation, support should be obtained from:  
Carla Kmett Danielson, Ph.D., National Crime Victims Research & Treatment Center, Department of Psychiatry & Behavioral Sciences, Medical University of South Carolina |
|---|---|
| Training Materials & Requirements | List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.  
How/where is training obtained? Contact Dr. Danielson (see contact info below).  
What is the cost of training? Contact Dr. Danielson.  
Are intervention materials *(handouts)* available in other languages?  
☐ Yes ☑ No  
If YES, what languages? N/A  
Other training materials &/or requirements *(not included above)*:  
Completion of TF-CBT training is highly recommended. |
| Pros & Cons/Qualitative Impressions | What are the pros of this intervention over others for this specific group *(e.g., addresses stigma re. treatment, addresses transportation barriers)*?  
Addresses a wide range of interrelated symptoms within one intervention (i.e., symptoms and risk behaviors are not treated in isolation of each other); addresses traditional barriers associated with this difficult-to-reach population; tailored to individual adolescent and family based on family’s goals for treatment, needs, and strengths; only exposure-based therapy that addresses both PTSD symptoms and substance use/abuse in adolescents with empirical support to date.  
What are the cons of this intervention over others for this specific group *(e.g., length of treatment, difficult to get reimbursement)*?  
Treatment can last several months (4-6 months) depending on the adolescent  
Other qualitative impressions: N/A |
### General Information

| **Contact Information** | **Name:** Carla Kmett Danielson, Ph.D.  
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**Email:** danielso@musc.edu  
**Website:** http://academicdepartments.musc.edu/ncvc/about_us/faculty/danielson_bio%2013.htm |